Presented to the HONORABLE WILLIE L. BROWN, JR.

Achieving Health Insurance for San Francisco's Uninsured

A Report of the
Mayor's Blue Ribbon Committee
on Universal Health Care
May 1998

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TABLE OF CONTENTS

MAYOR'S BLUE RIBBON COMMITTEE ON UNIVERSAL HEALTH CARE

The purpose of this report is to provide the City and County of San Francisco with a framework for extending health care coverage to uninsured residents. The Blue Ribbon Committee on Universal Health Care ("Committee") was formed under the direction of Mayor Willie L. Brown and began meeting in November 1996. The Committee members were:

Dwayne Banks, former Professor of Public Policy, Richard and Rhoda Goldman School of Public Policy at the University of California at Berkeley

Xavier Barrios, M.D.

Al Casciato, San Francisco Retirement Board

Richard Chambers, Associate Regional Administrator, Region IX Health Care Financing Administration

Jennie Chin Hansen, Executive Director, On Lok Senior Health Services

Sunny L. Clark, Director of Student Health Services, San Francisco City College

Alfredo Czerwinski, M.D., Lawson & Associates

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Emery "Soap" Dowell, California Managed Risk Medical Insurance Board.

Karen Hargarther-Thomas, Senior Vice President, Stone, Marraccini & Patterson

Sandra Hernandez, M.D., Chief Executive Officer, San Francisco Foundation (Committee Chair)

Gwen Kaplan, Principal, Ace Mailing

Mitchell Katz, M.D., Director of Health, San Francisco Department of Public Health

Sue Lee, San Francisco Redevelopment Agency (formerly with the Mayor's Office of Economic Development)

George D. Monardo, Davies Medical Center

During the course of its meetings, the Committee relied on the work of work of two subcommittees. The Committee would like to acknowledge the assistance of the following individuals who lended their expertise to these sub-committees: Dennis Lum (Kaiser Permanente), Janie Tyre (San Francisco Health Plan), Rogene Willis (Kaiser Permanente) and Monique Zmuda (San Francisco Department of Public Health).

The Committee would also like to acknowledge the work of the following individuals who prepared preliminary governance proposals: Keith Hearle (Jurika & Voyles, formerly with the San Francisco Department of Public Health), Margaret Kisliuk (MetroPlus Health Plan, NY, formerly with the San Francisco Department of Public Health), Shahnaz Nikpay and Janie Tyre (San Francisco Health Plan), Richard Pettingill and Cathy Chen (Kaiser Permanente), and Robert Prentice (San Francisco Department of Public Health).

The Committee wishes to acknowledge and thank Tangerine Brigham, Director of Policy and Planning in the San Francisco Department of Public Health for providing planning, policy, organizational support and tireless effort.

EXECUTIVE SUMMARY

An estimated 130,000 San Franciscans are uninsured. The uninsured have greater difficulty obtaining needed medical care and have lower health status. Despite growth in our local economy and nation-wide reductions in health premium increases in the past three to four years, the number of uninsured has not decreased.

In response to the 1996 San Francisco Health Summit, Mayor Brown appointed a Blue Ribbon Committee on Universal Health Care Coverage ("Committee"). The Committee began meeting in November 1996 to develop recommendations on how the City and County of San Francisco ("CCSF") might best pursue expanded health care coverage for the uninsured. The Committee included health care providers, insurers, consumers, employers, community-based organizations, labor and health advocates. The Committee established the following goals:

- to make health insurance affordable and available to all San Francisco residents,
- to define a standard, comprehensive benefits package for indigent care,
- to offer choice of providers and/or health plans and
- to promote preventive and primary care.

While these goals directly effect the uninsured, achieving them also benefit the entire San Francisco community. They further our efforts to ensure the health and welfare of all residents.

The Committee is recommending a program that makes health insurance more affordable by:

- enabling employers to participate in a purchasing pool that leverages their contributions for health care coverage and
- providing a subsidy for low-income workers and the indigent.

The estimated monthly health care premium is $139 per enrolled person - well within the industry standard.

The Mayor's Blue Ribbon Committee on Universal Health Care makes the following recommendations for expanding health care coverage to San Francisco's uninsured population:

What Should Be Created and Offered To Expand Coverage?

- Multi-Payor Purchasing Program: Create a purchasing program to expand health care coverage to the uninsured. The purchasing program would pool premiums from employers and members, and indigent care dollars from the CCSF. By pooling funds, purchasing programs are able to make health care premiums more affordable for small businesses. It would contract, on behalf of employers and individuals, with health plans to provide affordable preventive, outpatient and inpatient insurance coverage. While participation in the purchasing program would be entirely voluntary, the more employer participation in this program the better.

- Scope of Benefits: Adopt the following minimum benefits package:
  - preventive care,
  - primary and continuity care,
  - prescription drugs,
  - hospital care (inpatient and emergency room),
  - vision care for minors,
  - physical therapy,
  - home care,
  - skilled nursing care (60-day limit),
  - limited mental health (inpatient and outpatient) and
  - limited substance abuse (outpatient and inpatient detoxification).

  Employers who are either willing, able or required by memorandums of understanding to provide broader coverage can request that the purchasing program do so. This may include dental, vision and other benefits coverage.

Who Should Be Eligible For Enrollment?

- Eligible Population: Allow the following to be eligible for participation in the purchasing program:
  - *Employers*: Businesses are eligible to enroll their employees and dependents into the program. Small employers and self-employed individuals would also be eligible.
  - *Uninsured Working Adults*: Working uninsured will be eligible for enrollment either through their employer, or as an individual if their employer chooses not to participate.
  - *Uninsured Children above 200% of federal poverty level*: These children do not have access to publicly-supported health care. Most children under 200% of the federal poverty level are eligible for either Medi-Cal or Healthy Families and therefore will not be covered through this purchasing program. Children who are under 200% of the federal poverty level and are ineligible for publicly-supported health care could enroll in this program.
  - *Uninsured College Students*: Low-income college students will be eligible for the program.
  - *Uninsured Non-working Adults*: These individuals who have traditionally relied on a safety net system will be eligible for the purchasing program.

The Committee recognizes that, if necessary, these eligible populations may be prioritized for staggered enrollment into the purchasing program.

- CCSF Employees, Retirees and Dependents: Encourage the CCSF to be the first employer into the purchasing program. Inclusion of CCSF employees and retirees (along with their dependents) into the program will maximize purchasing leverage and will reduce administrative costs. The authority to purchase health benefits on behalf of these individuals would be transferred from the current CCSF Health Service System to this new purchasing program. No reduction is being proposed in the scope of benefits offered to CCSF employees, retirees and dependents.

- Additional Populations: Consider the purchasing program as a mechanism for buying health care for additional populations, such as other large employers and Medicaid beneficiaries. This would enable the purchasing program to capitalize on its increased size (i.e., number of members), to access another source of funding, to efficiently purchase health care through economies of scale and to support the extension of health care to low-income residents who are not CCSF employees.

- Residency Requirement: Consider establishing a waiting period (e.g., continuous six-month San Francisco residency) requirement for individuals to enroll in the purchasing program (those enrolling without employer sponsorship). Persons who work in San Francisco, but live elsewhere, may be enrolled in the program only if their employer participates. In those cases, the six-month residency requirement would not apply. This residency requirement does not refer to immigration status. Any documented or undocumented resident will be eligible for the program if they have resided in the CCSF for at least six months. Any enrollee who qualifies for a premium subsidy will be required to meet the residency requirement.

How Should This Purchasing Program Be Designed and Structured?

- Governance: Create a governing body to oversee implementation of the purchasing program. The purchasing program would be a non-profit, public benefit corporation.

- Financing:
  - Purchase coverage through a combination of employer premiums, member premiums and co-payments, and CCSF indigent care subsidies for low-income enrollees.
  - Means testing is proposed for members to appropriately target any CCSF premium subsidy. Only members with household income below 300% of the federal poverty level would be eligible for a CCSF subsidy. A person would

have to wait six (6) months to become eligible for the subsidy. No CCSF subsidy would be allowed for a person who works in San Francisco but lives in another county.

- Tie the level of member premiums and co-payments to income. Non-working members would not be required to pay either a premium or a co-payment.
- Use risk adjustment in developing appropriate rates for plans serving those with chronic illnesses or those at high risk of chronic illness.

- Contracting Credits: Adopt an ordinance which credits San Francisco businesses who are competing for CCSF contracts with bidding points for providing the proposed scope of benefits or comparable benefits to their employees.

This report does not attempt to outline any operational issues associated with implementation. However, the Committee recommends phasing-in this effort to allow the purchasing program's governing body the ability to study cost and enrollment issues before attempting to enroll all uninsured residents. It is also critical that an on-going evaluation of the program's effectiveness in increasing voluntary participation in the health insurance market be done. The following next steps are recommended to implement the proposed purchasing program:

- Pre-implementation Feasibility Study: Conduct a feasibility study which, at a minimum, should include a business plan, a marketing and sales plan, and additional actuarial analysis.

  In addition, the Committee believes that a survey of San Francisco small businesses with fewer than 30 employees should be undertaken in conjunction with insurance brokers. Such a survey can more definitively determine whether the low-income worker subsidy and the estimated premium rates will attract new employer and employee participation in the health insurance market.

- Design a Phased-In Implementation: The Committee believes that it is important to have both public and private employer participation. This is a fundamental tenet of the purchasing program's design. The governing body, once appointed, will need a capable, but small administrative structure to design a phased-in implementation. Developing a marketing strategy which assures both public and private participation is vital.

- Develop an Evaluation Component: Evaluation of the purchasing program must begin in the early phases of the program's design. Measurable objectives must be identified and should include, but are not limited to:
  - measuring the number of uninsured,
  - instituting quality of care measures,
  - developing member feedback and satisfaction measures,
  - using public health measures (e.g., immunization rates, mammogram rates, cancer screening, safe and healthy behaviors, and disease control) and
  - determining the impact of the program on various stakeholders in the health care industry, especially safety net providers (i.e., patient volume, case-mix and revenues should all be monitored).

  In addition to evaluating the purchasing program, on-going documentation of the project will be needed. Many other urban and/or regional areas will be very interested in the success (or failure) of this public-private effort. The media, academia, researchers and policy makers will be interested in the project and some should be involved in the evaluation.

The Committee believes that the CCSF's success in reducing the number of uninsured rests in a voluntary approach to health care coverage. Federal law prevents the CCSF from creating a mandatory program -- as designed, neither employers nor individuals will be required to enroll in the purchasing program. In addition, the Committee

discourages a regulatory or punitive approach to expanding health insurance. Employer participation into the purchasing program will be voluntary. The proposed design and model of the program has the potential to significantly expand affordable coverage to employers who are not providing coverage. These employers will be incentivized to come into the purchasing program based on a CCSF subsidy for low-income workers and on affordable employer premiums. Nonetheless, the Committee strongly believes that the purchasing program must aggressively reach out to employers, working uninsured, college students and others to ensure that the program enrolls the maximum number of uninsured residents. Education, outreach and the use of insurance brokers are critical to the success of any voluntary health insurance programs.

This report contains thirteen (13) sections which are organized in the following manner. Sections I through III of the report introduce the reader to the uninsured problem. They provide background information on health insurance status, the health care delivery system and on financing care for the uninsured. In Sections IV and V, the Committee's objective, goals and guiding principles are presented along with a discussion of the various policy issues involved in extending health care coverage. Sections VI encompass the Committee's recommendations on the mechanism for expanding coverage, eligible population, scope of benefits and model of care. Section VII provides the estimated cost and proposed financing involved in expanding coverage.

Starting with Section VIII, the Committee provides its recommendations on a governance structure and Section IX discusses financial risk. Section X outlines the purchasing program's responsibilities to the CCSF. Section XI discusses the impact of expanding health care coverage to the uninsured on the safety net. Section XII provides information on the community forums and presentations held to discuss the proposed purchasing program. Finally, in Section XIII the Committee outlines the implementation issues involved in developing the purchasing program.

The Committee acknowledges the tremendous complexity of health care financing. We have benefited from months of analysis and deliberations. There are, of course, many stakeholders involved in any health care reform initiative. We believe that San Francisco has the needed policy leadership and commitment to pursue the goals outlined in this report. San Franciscans as a community will need to remain focused on the goal and have the courage to move forward despite the inevitable voices of cynicism and self-interest. San Francisco's insured currently enjoy the best health care delivery of almost any place in the world. Working together, the public and private sector have the ability and capacity to extend this care to everyone. We hope you will read this report with an eye toward what you can do to this end.

I. INTRODUCTION

An estimated $4,065 was spent per capita on health care services in San Francisco -- a total of $3.06 billion -- in 1996. Despite this level of expenditure and the ready availability of primary care, hospitals, clinics and physicians in San Francisco, too many residents lack health insurance. These children, college students, single adults, mothers and fathers have little opportunity to receive routine preventative care and limited ability to pay for unexpected emergencies. Their care is sporadic and expensive, and results in higher morbidity, lost productivity and poorer overall quality of living.

The passage of the Personal Responsibility and Work Opportunity Act of 1996 ("Welfare Reform") threatens to increase the number of uninsured by allowing states to "de-link" Medicaid eligibility from welfare eligibility and by imposing a lifetime limit on the receipt of welfare benefits. Welfare reform seeks to move welfare recipients into jobs. For this transition to be successful, expansion of employer-based health insurance is necessary to keep children and families covered, and to keep employees at work.

In August 1996, Mayor Brown convened the San Francisco Health Summit to discuss health care issues. Individuals from health care, business, academia, labor, government and the community met to discuss various matters ranging from health indicators to provider training. During the Health Summit, participants raised concerns regarding the rise in the number of uninsured. The consensus of Health Summit participants was that while San Francisco had a number of health care resources (such as primary care clinics), it needed to focus its efforts on improving access to health care for all San Franciscans, particularly the uninsured.

When a person is uninsured, they often lack access to a regular provider who they can call upon when ill and whom they can obtain preventive health care maintenance and early detection services from. On average, the uninsured receive about 60% of the

health services received by the insured.[1] As a result, the uninsured have lower health status and higher rates of preventable diseases and injuries. Because the uninsured are primarily low-income, working people they must either self-pay for the entire cost of care or seek eligibility for sliding scale payments. The fear of receiving high medical bills that they may be unable to pay cause many uninsured to delay seeking treatment when they are ill. The lack of access to a regular primary care provider and the high out-of-pocket expense often result in the uninsured obtaining care at expensive hospital emergency rooms. Research shows that the uninsured are more likely to be hospitalized for conditions that can be more appropriately treated in outpatient settings.[2] The uninsured are at greater risk of poor health outcomes. When the uninsured do seek services, their ailment is generally more advanced and is often times more difficult to treat.

The uninsured usually have difficult obtaining care. Private physicians, hospitals and clinics are increasingly less able to provide uncompensated care to the uninsured. Continued reductions in fee-for-service rates and the increased use of risk-based, pre-paid capitation have virtually eliminated all revenue margins and the ability to cost-shift.

In San Francisco, the uninsured have some access to primary, acute and specialty care due to community-based, non-profit and public providers. For example, estimates are that 54% of the uninsured obtain services at the Community Health Network (the integrated delivery system of the San Francisco Department of Public Health). However, even these traditional and safety net providers are having difficulty continuing services to this population. An increasingly competitive health care environment has strained the ability of providers to offer free or reduced cost care to

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[1] Congressional Budget Office. Behavioral Assumptions for Estimating the Effects of Health Care Proposals. 1993

[2] J.S. Weissman, C. Gastonis, and A.M. Epstein. "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland." Journal of the American Medical Association. Volume 268. 1992

the poor and uninsured.[3] Community health centers, public hospitals and public clinics are: (1) witnessing changes in the mix of patients who have a source of payment for their care and those who do not, (2) adjusting to capitated financial arrangements and (3) dealing with adverse federal policy which has brought about a reduction in revenues.

Regrettably, our nation has historically tolerated a high number of uninsured -- at over 40 million people today. Prior to the enactment of Medicaid and Medicare in 1965, almost one-third of the population was uninsured. While the percentage declined after the creation of these two programs, the percentage of uninsured has been increasing since the 1980s. The following reasons have been offered to explain our nation's seeming willingness to accept the uninsured:

- the number of uninsured people is exaggerated,
- being uninsured is a temporary situation for most people,
- many people choose to be uninsured,
- the uninsured get care anyway,
- providing universal health insurance coverage is the right thing to do, but we cannot afford it at this time,
- government is untrustworthy and
- the American political system is a barrier to sweeping national changes.[4]

These beliefs (some legitimate and others not) have led to apathy among citizens and legislative leaders. Addressing the uninsured problem will require that we combat these beliefs and dispel other myths about the origins and solutions to the uninsured problem.

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[3] Stuart Altman, Uwe Reinhart and Alexandra Shields (eds.), The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?, 1998

[4] Steven A. Schroeder, M.D., "The Medically Uninsured -- Will They Always Be With Us?," New England Journal of Medicine, April 25, 1996

Following the Health Summit, in November 1996, Mayor Brown appointed a Blue Ribbon Committee on Universal Health Care ("Committee"). The principal objective of the Committee's work was to recommend an expanded health care coverage program for the uninsured. The initiative was designed to give employers in the City and County of San Francisco ("CCSF") an opportunity to improve the availability of health insurance, to improve health status and health outcomes, and to better manage health care expenditures. The Committee included providers, advocates, health care consumers, business representatives, community leaders, and State and federal officials. All Committee members shared a broader view that the provision of health care coverage is a community responsibility and should be encouraged, but not mandated.

The major factors that should be taken into account when developing any system to expand health care coverage to the uninsured are:

- affordability: the program must be affordable if it is to attract employers and employees,
- perceived need for health care: people have different needs for health insurance and health care depending upon their family circumstances and beliefs,
- mandatory versus voluntary participation: there are no provisions either federally or on a state level that require employers to offer coverage nor is there any law which requires an individual to have health insurance,
- maintaining employer-based and individually purchased insurance: the program should not result in employers and/or individuals dropping their existing health insurance coverage to enroll in a program with the potential of having some portion of the cost subsidized (i.e., "crowd-out" should be minimized) and
- ensuring public sector health insurance: the program should actively encourage, not discourage, persons and families eligible for other publicly-supported health care to apply for and obtain coverage in these state/federally funded programs.

Given these factors, purchasing alliances were explored in-depth by the Committee. Under this model, health care funds are pooled from a variety of sources (employers, members, public sector and private sector) to purchase more affordable health care on behalf of an enrolled population. Purchasing alliances offer the ability to spread financial risk (i.e., actuarial) across more covered lives, the opportunity to ensure member choice and the ability to offer a comprehensive benefits package(s). The Committee believes that a public-private purchasing alliance could help meet the City and County of San Francisco's goal of expanding health care coverage.

II. SAN FRANCISCO'S CURRENT HEALTH CARE COVERAGE PROFILE

San Francisco has an estimated total population of 773,000.[5] Our ethnically and economically diverse population includes African Americans, Asian Americans/Pacific Islanders, Latinos and Native Americans which represent more than one-half of the CCSF's population. Approximately 85,000 to 100,000 residents are refugees or immigrants. Based on 1990 census data, roughly 13% of the CCSF's households live below the federal poverty level. An estimated 7,000 to 8,000 San Francisco residents are homeless.

Health insurance provides financial protection against medical care costs arising from injury or disease. The insurance can cover all or a portion of the costs. Persons obtain health insurance through three major vehicles: (1) either through their employment on a group basis, (2) through purchasing it directly in the individual health insurance market or (3) by qualifying for publicly-supported health insurance. Individuals who cannot obtain health insurance under one of these mechanisms are considered uninsured -- that is, they have no financial protection to cover the costs of medical expenses. Table 1 provides a profile of health care coverage in San Francisco:

Table 1[6]

Health Coverage Status	Estimated Perc. of Population	Estimated No. of Residents
Employer-Based Coverage	53%	407,900
Individually Purchased	6%	46,400
Publicly-funded Health Care		
A. Medi-Cal	9%	73,200
B. Medicare	15%	115,500
Uninsured	17%	130,000

[5] California Department of Finance, January 1997 estimate

[6] Total number of eligible Medi-Cal beneficiaries in December 1997 was approximately 100,500. Approximately 27.2% of Medi-Cal eligible are also eligible for Medicare (27,336 persons). Medi-Cal recipients who are also covered under Medicare are classified as having Medicare as their primary source of coverage

In total, 83% of our residents have some form of health insurance. However, despite a vigorous economy, a low unemployment rate and decreasing numbers of General Assistance recipients, current estimates are that 130,000 residents -- 17% of San Francisco's population -- have no health care coverage.

A. Employer-Based Coverage

The nation's uninsured crisis is in large part due to the fact that our health care insurance model is strictly voluntary. Specifically, employment-based health care is voluntary. Research indicates that uninsured rates are higher in localities with a high concentration of small businesses and "underground economy" jobs that do not typically provide health insurance.[7]

As health care costs have risen, more employers either have chosen not to or been unable to offer health care coverage to their employees. Providing health care coverage increases employers' costs of operating their businesses. Between 1989 and 1995, the percentage of working age adults (18 - 64 years old) with private health insurance decreased from 76% to 73%.[8] Decreases in the number of employers who offer health care coverage increase the number of uninsured. This has been somewhat exacerbated by the increasingly common practice of employers offering employees the option of cash compensation in lieu of health benefit contributions.

Table 2 on the following page was developed as part of the 1997 UCLA-KPMG Employer Health Benefits Survey and provides estimates of firms offering health care insurance in the San Francisco Bay Area:

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[7] Raymond Baxter and Robert Mechanic, "The Status of Local Health Care Safety Nets." *Health Affairs*, Volume 16, Number 4, July August 1997, pp. 7-23

[8] United States General Accounting Office, Employment-Based Health Insurance: Costs Increases and Family Coverage Decreases, February 1997

Table 2

Number of Employees	% of Firms that Offer Coverage	% of Employees Offered Coverage	% of Employees Accepting Coverage
3 - 9	51%	56%	72%
10 -25	78%	78%	76%
26 - 50	92%	90%	74%
51 - 199	96%	97%	67%
200 - 999	100%	100%	74%
1,000 or more	100%	100%	62%

As the table reveals, there is a strong correlation between the size of the business and the business' ability to offer health care coverage. Individuals employed by medium-sized and/or large firms are more likely to be offered health care coverage. Employees of smaller firms and/or those who are low-wage earners are more likely to be uninsured. Small businesses are defined as those with 2 to 50 employees.

In comparison to state-wide figures, San Francisco Bay Area small employers are more likely than other small employers to offer coverage. For example, state-wide, only 32% of all surveyed employers with 3 - 9 employees offered health care coverage in comparison to 51% in the San Francisco Bay Area.[9] Based on these findings, the Committee has focused particularly on how best to reach those small firms with fewer than 26 employees.

Employers (most often small businesses) cite the following reasons for not providing health insurance:[10]

- health insurance premium costs are too high,
- firm profits are too uncertain,
- employees would rather have more "take-home" pay,

[9] The state-wide survey data indicates the following for small employers. 32% of firms with 3 - 9 employees, 69% of firms with 10 - 25 employees and 81% of firms with 26 - 50 employees offer health insurance.

[10] Health Insurance Policy Program. The State of Health Insurance in California, 1997. January 1998

- firm cannot qualify for group coverage,
- employees are covered elsewhere,
- administrative hassle to manage coverage and
- employee turnover is too high.

As the listing above indicates, the financial instability of small firms deters these employers from offering health insurance. Other research has found that small employers do not see offering health insurance as necessary to attracting workers.[11] Interestingly, statewide only 20% of the firms participating in the UCLA-KPMG survey indicated that they were philosophically opposed to providing health coverage.[12]

Table 2 also indicates that not all employees who are offered health care coverage accept it. Monthly premium costs, as well as the ability to obtain coverage under another family member's employer affect an employee's decision to accept heath care coverage from their employer. A recent study found that workers earning less than $10 per hour were more inclined not to take employer-based health coverage when it was offered by employers.[13] Thee employees cannot afford to pay their portion of the monthly health care premium because of their relatively low wage - paying a health care premium reduces their take-home pay. This is supported by the fact that surveys of small employers indicate that some employees would prefer to have a higher wage than have the employer contribute to health insurance premiums

B. Private Individual Health Insurance

A significant number of workers purchase individual health insurance through the private insurance market because they do not have access to employer-based coverage or publicly-supported health care. Individual health insurance is most commonly

[11] Philip Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers For Employment-Based Health Insurance 1987 and 1996," *Health Affairs*, Volume 16, Number 6, November December 1997, pp 142 - 156

[12] The State of Health Insurance in California, 1997

[13] Cooper and Schone

purchased through insurance agents and brokers. In 1996, an estimated 16 million Americans under 65 years of age relied on the private individual health insurance market.[14] Estimates are that fewer than 6% of Californians under 65 years of age have privately purchased health insurance.[15] Individuals who typically participate in the private health insurance market are:

- self-employed persons,
- persons whose employers do not choose to offer health insurance coverage,
- part-time, temporary or contract workers ineligible for health insurance through an employer,
- college students,
- unemployed persons who are ineligible for Medicaid,
- persons between jobs who have exhausted or are ineligible for continued employer-based coverage and
- children, spouses and other dependents ineligible for employer-based coverage.

The cost of obtaining coverage through the private individual health insurance market is more expensive for a person than if the coverage were obtained from an employer. This is because the person must pay the entire health premium. As a result, a person's income and assets are key in determining whether or not the person purchases private individual health insurance.

In addition, medical underwriting is used in the individual health insurance market. Medical underwriting is a process by which a person's pre-existing condition or health status may result in the person either being denied coverage or paying higher premiums. Some people are unable to obtain health insurance through the private insurance market because they are "medically uninsurable" meaning that they have a

[14] Deborah J. Chollet and Adele M. Kirk, Understanding Individual Health Insurance Markets, Alpha Center, March 1998

[15] The State of Health Insurance in California, 1997. The Committee has assumed the same percentage for San Francisco

chronic health condition that results in high utilization and expenditures. California's Managed Risk Medical Insurance Program (MRMIP) is a small initiative (limited to 19,500 persons) which provides health insurance to those who can afford health coverage, but cannot secure it in the private individual health insurance market. In San Francisco, approximately 600 residents receive health insurance under MRMIP.

C. Publicly-Supported Health Coverage

California has two publicly-supported health insurance programs for low-income and elderly persons: Medi-Cal and Medicare. In addition, the State will implement a new publicly-supported health insurance program for children -- Healthy Families -- in the summer of 1998. All three programs are funded by the federal and State governments.

i. Medicaid

Medicaid provides medical assistance for certain individuals and families with low incomes and resources. It has served as the federal government's primary vehicle for expanding health care coverage to low-income citizens. It provides health insurance to almost 36 million people nationally, acting as a safety net for those unable to purchase individual health insurance. In California, the program is called Medi-Cal and serves approximately 5 million people. Approximately 100,000 San Francisco residents are Medi-Cal recipients.[16] This number has been steadily declining. In San Francisco the percentage of Medi-Cal recipients who participate in CalWORKS is roughly the same as those receiving Social Security Income.

Medicaid covers about half of poor Americans. This is because being poor does not automatically qualify you for Medicaid. Only persons who are within certain eligibility categories qualify such as low-income children, pregnant women, the elderly and people with disabilities. Medicaid pays for the following health services

[16] This figure includes those receiving only Medi-Cal (73,200) and those receiving both Medi-Cal and Medicare (27,336)

- inpatient and outpatient hospital,
- physician, midwife and certified nurse practitioner,
- laboratory and X-ray,
- nursing home and home health care,
- early and periodic screening, diagnosis and treatment for children under age 21 and,
- family planning.

California also provides additional benefits such as prescription drugs, clinic services, dental, chiropractic and podiatry services. Overall, California's Medi-Cal program has a broad scope of benefits, but the eligibility process and the need to maneuver through a complex system are enormous deterrents that sometimes prevent eligible families from applying for benefits.

In 1992, the State Department of Health Services (DHS) was given broad authority to enroll Medi-Cal beneficiaries into managed care or pilot programs. San Francisco was one of twelve counties across the State which were mandated to deliver health services to certain Medi-Cal beneficiaries through what has become known as the "Two-Plan Model." These CalWORKS beneficiaries must enroll in one of the two health plans offered. In San Francisco, the two health plans are the San Francisco Health Plan and Blue Cross of California. Currently, 33,500 Medi-Cal recipients are enrolled in managed care in San Francisco.

ii. Medicare

Medicare provides health insurance for roughly 37 million elderly and disabled people. Almost 90% of Medicare recipients are over the age of 65. The Medicare program consists of two parts: (1) hospital insurance (Part A) and (2) supplemental medical insurance (Part B). Eleven percent of Californians are enrolled in Medicare. Currently, 115,500 San Franciscans are enrolled in Medicare (this figure includes those enrolled in both Medicare and Medicaid).

Medicare's hospital insurance program covers hospital inpatient services, home health, hospice and skilled nursing care (which is limited to 100 days). Under the supplemental medical insurance portion of Medicare, recipients access physician services, hospital outpatient care, laboratory services, durable medical equipment and other ambulatory care.

Medicare is critical to ensuring that those over 65 years of age have access to care and it is the principal reason why the uninsured are primarily under the age of 65. However, it does not generally provide all of the services that a person might receive through employer-based coverage. Medicare does not cover prescription drugs, imposes higher deductibles than Medicaid and does not limit the amount of money that a beneficiary has to pay out-of-pocket. Because of this, many Medicare beneficiaries purchase supplemental insurance to cover the cost of services not covered under Medicare.

iii. Healthy Families

In 1998, California will phase-in a new program designed to expand health care coverage to uninsured children. The California Healthy Families Program will provide health insurance coverage (health, dental and vision) to uninsured children under 200% of the federal poverty level ($27,300 for a family of three) who are ineligible for Medi-Cal. The program covers children aged 1 up to 19.

California is creating the Healthy Families Program in response to the recently enacted federal Children's Health Initiative Program. This program provides federal funding for states to expand health care coverage to uninsured children under the age of 19. An estimated 580,000 children in California are eligible for Healthy Families. In San Francisco, an estimated 3,000 - 6,000 children are eligible for the program.[17] Under Healthy Families, children will have access to:

[17] Steve Wallace, PhD, Tanya Burton, MSPH, Hongjian Yu, PhD and E. Richard Brown, PhD, "Uninsured Low-Income Children Eligible for California's Healthy Families Program," December 1997

- hospitalization,
- physician, medical and surgical services,
- outpatient services,
- prescription drugs,
- family planning,
- mental health,
- dental benefits,
- vision services and
- occupational, physical and speech therapies.

Families who enroll their children in Healthy Families are required to pay monthly premiums and co-payments for non-preventative services. The monthly premium amount depends upon the family's income and number of children enrolled in the program. However, in general, premiums fall within the following categories:

Table 3

Number of Children	Income 100% to 150% FPL	Income 151% to 200% FPL
1	$7	$9
2	$14	$18
3 or more	$21	$27

Families will be able to obtain discounts on their premium if they select the Community Provider Plan as their child's health plan. The Community Provider Plan is the health plan with the highest concentration of traditional and safety net providers. For the purposes of Health Families, this is based on participation of Child Health and Disability Prevention providers, clinics and hospitals in the provider network. In San Francisco the Community Provider Plan for Healthy Families is the San Francisco Health Plan.

III. SAN FRANCISCO'S UNINSURED RESIDENTS

An estimated 130,000 San Franciscans (or 17% of the population) are uninsured.[18] These residents lack any form of private or public health insurance. These estimates were derived utilizing the most Current Population Survey and National Medical Expenditure Survey.[19] Below the Committee discusses the barriers that prevent more residents from having health insurance, provides demographic information on San Francisco's uninsured, highlights the implications of not having health insurance and summarizes the funding of health care for the uninsured.

A. Causes of Uninsurance

The reasons why the uninsured lack coverage are both obvious and subtle. Some having to do with financial ability to pay for coverage, knowledge of publicly-funded health care and the perceived need for coverage. The following provides the major barriers facing the uninsured:

- Lack of employer coverage -- A significant percentage of the uninsured are working, these individuals may not have access to employer-based health care coverage either because they do not meet the employer's criteria for eligibility (e.g., minimum number of hours worked per week) or their employer does not offer coverage.
- Cost -- A person may be unable to afford the cost of coverage on the individual health insurance market or to pay their portion of the premium cost if coverage

[18] San Francisco County Estimates of Health Insurance conducted by Andrew Bindman, M.D., Associate Professor of Medicine and Epidemiology, University of California at San Francisco

[19] While a primary data survey was not developed to obtain the estimated number of uninsured, several sources support the estimated number of uninsured San Francisco residents, specifically

- the CCSF's Controller's Office citywide survey for 1997 found that 15% of the respondents had no health insurance,
- the UCLA Center for Health Policy Research found that 17% - 29% of those aged 0 to 64 are uninsured and
- a 1997 report by the Institute for the Future estimated the number of uninsured to be 16% in San Francisco.

is available from their employer. Uniformly, cost is cited as the single most important factor contributing to a person's uninsured status.

- Pre-existing conditions -- Because underwriting is still practiced in California, insurers may deny coverage to persons based on their health status. Persons with chronic pre-existing conditions sometimes find it difficult to obtain coverage, and if they are able to obtain coverage, the cost is generally more expensive.
- Perceived need for health insurance -- Some uninsured do not equate health insurance with health care and therefore see no value in either seeking routine care or purchasing insurance. These individual may or may not be able to afford health insurance. Those who are financially able to pay for coverage, but do not buy it may see themselves in good health and only think of health insurance for those who are in bad health. These individuals generally do not believe in insurance or believe that they will someday need care.
- Attitudes and knowledge about public health insurance -- Some uninsured are eligible for publicly-supported health care, but may be unaware of their eligibility. In these cases additional education and outreach is needed to inform the uninsured that they can obtain health insurance. Others may be aware of the programs, but are reluctant to apply because they associate the receipt of publicly-supported health care with welfare and/or find the application process cumbersome, intrusive and uninviting. In addition, literacy, language and cultural barriers can also prevent individuals and families from knowing about and applying for such programs as Medi-Cal.
- Ineligibility for public assistance -- Some low-income uninsured, due to their legal status (i.e., recently arrived legal immigrants and undocumented residents) are ineligible for publicly-supported health care. As a result of welfare reform, recently arrived legal immigrants are ineligible for public assistance for their first five years in the United States. Undocumented residents have not been eligible for either Medi-Cal or Medicare.

B. San Francisco's Uninsured Population

Table 4 segments the uninsured into four categories: working adults, indigent adults, other adults, and children and youth. San Francisco's uninsured population follows a state-wide pattern in that the majority of uninsured (over 80%) are workers (either full or part-time) or are members of working families.[20] However, a majority of the working adults are employed by small businesses which have historically had lower rates of offering health coverage. As the table below indicates an estimated 10% of San Francisco's uninsured are 18 years of age or younger.

Table 4

Uninsured Category	Est. Number of Persons	Percentage
Working Adults (Full-time, Self-Employed and Flex Work Force)	88,000	68%
Indigent Adults (General Assistance Recipients, Homeless)	18,000	14%
Other Adults (Non Working Adults, Low-Income College Students)	11,000	8%
Children and Youth	13,000	10%
All Uninsured	**130,000**	**100%**

The Committee recognizes that many low-income college students may be working, especially in part-time jobs. However, the Committee does not have accurate information on employment among college students. Given this, the Committee felt that it was appropriate to list college students under the "other adults" category. Health care coverage among college students differs widely among institutions. In San Francisco, college students at four-year institutions are more likely to have health coverage than those at two-year institutions. At California State University at San Francisco, a survey found that two-thirds of the students had health insurance.[21] This is

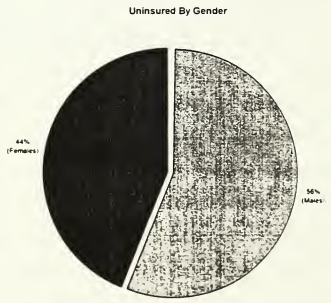
[20] The State of Health Insurance in California, 1997.

[21] Myra Lappin, M.D., "San Francisco State Student Health Needs Survey," Public Research Institute, May 1996.

in stark contrast to information obtained by the Health Services Department at City College where an estimated 82% of those surveyed were uninsured.[22]

State-wide demographics indicate that a disproportionate number persons of color are likely to be uninsured. In particular, Latinos have a higher percentage of uninsured within their population -- at 35%. African-American and Asian-Americans/Pacific Islanders have similar proportions of their populations without health insurance -- at 25% and 23% respectively. Within European-Americans, 14% of their population is estimated as being uninsured.[23] The Committee believes that these State characteristics are seen in San Francisco's uninsured population.

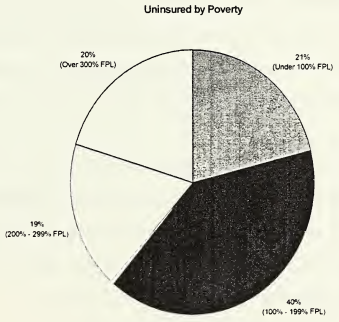
More men (56%) than women (44%) are uninsured.



As the graph on the next page indicates, 60% of the uninsured have incomes below 200% of the federal poverty level. For a family of one this would be equivalent to $16,100 a year, for a family of two $21,700 a year and for a family of three $27,300 a

[22] San Francisco City College. Health Services Department.
[23] The State of Health Insurance in California. 1997

year.[24] In high cost urban areas such as San Francisco, the ability to afford health care coverage becomes difficult after paying for other necessities.



According to the 1990 Census, the San Francisco neighborhoods with the highest percentage of their population in poverty (i.e., over 32% of the residents are at or below 100% of FPL) were: Bayview Hunters Point, Visitation Valley, portions of the Tenderloin and portions of Chinatown. Neighborhoods with fairly high percentages of their population in poverty (i.e., between 16% and 32% of the residents are at or below 100% of FPL) were: additional sections in Chinatown, Civic Center/North of Market, South of Market, Mission, Potrero Hill, portions of Western Addition and additional sections of the Tenderloin.

San Francisco is home to a diverse immigrant community. While we do not have demographic information for the uninsured by immigration status, we estimate that a number of the uninsured are immigrants (both documented and undocumented residents). Undocumented residents have historically had very limited access to

[24] Appendix A provides the 1998 federal poverty guidelines

publicly-funded health care and firms that employ undocumented workers may have little incentive to provide health care to this population. As a result of the federal Personal Responsibility and Work Opportunity Act of 1996 (known as Welfare Reform) many documented immigrants are prohibited from applying for publicly-funded health care for a period of five years if entering the United States after August 22, 1996. Some of these individuals have neither employer-based coverage nor the ability to purchase private individual health insurance.

C. Consequences of Being Uninsured

While a person may be uninsured, this does not mean that they go without health care entirely. However, this also does not mean that their access to care is comparable to those who have insurance. The health care system is more difficult to access if you do not have health insurance. Research has found that 36% of the uninsured report having no usual source of care compared with 17% for those with private insurance and 12% for those with Medicaid.[25] When an uninsured person lacks a usual source of care, they must navigate a complex, fragmented health care delivery system.

This is problematic. For a needed appointment, they may call several clinics before finding one that can schedule a visit within the requested time-frame. Seeking services can involve the individual sitting through several screening sessions and completing a multitude of forms to determine if they are eligible for any publicly-supported health care. Lacking a regular provider, the uninsured will not have one medical record that contains a complete medical history of the person. They may have a different patient record at each site where they have seen a provider.

Health care utilization among the uninsured is less than health care utilization among those with health care coverage.[26] Because the uninsured are primarily low-income,

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[25] The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?

[26] Behavioral Assumptions for Estimating the Effects of Health Care Proposals

working people, paying for high cost medical care can be very prohibitive. While some may qualify for reduced sliding scale payments at certain clinics, others may not and even with a sliding scale, the cost of care may be too expensive. Knowing that they have limited financial resources and may be unable to pay their medical bills, the uninsured are less likely to seek services. As a result, when the uninsured do eventually seek services, their ailment is often more advanced and often times more difficult to treat because they have postponed obtaining care earlier.

Data from the San Francisco Department of Public Health ("DPH") indicates the following about indigent patients (i.e., uninsured) receiving services:[27]

- indigents constitute approximately one-half of the total patient population and indigents represent about one-half of discharges/visits and
- indigents have a much lower percentage of inpatient discharges/visits and expenditures as compared with non-indigents.

In 1997, the Departments of Public Health and Human Services conducted a match between their databases to determine the health care utilization of General Assistance recipients during fiscal years 1993-94 to 1995-96. The data indicated that during this three year period there were 29,000 General Assistance recipients and almost 50% had used DPH services, either at San Francisco General Hospital, the community-oriented primary care clinics or at Community Mental Health Services. The most common visit diagnoses for SFGH inpatient clinic visits among General Assistance recipients were: (1) mental disorders and (2) metabolic and immunity disorders.

[27] San Francisco Department of Public Health, Medically Indigent Care Reporting System (MICRS) Data Summary Report No. 5, November 1997. MICRS is a state-wide reporting requirement for Proposition 99 funds

D. Financing Care for the Uninsured

Over the last several decades local government and non-profit community clinics have increasingly taken on the role of providing health care services to indigent and uninsured persons.

Under California Welfare and Institutions Code Section 17000, California counties are required to serve persons with no private or public health insurance. Counties may provide services directly or contract with other private and non-profit providers to deliver services. Other community-based providers such as non-profit clinics also provide services to the uninsured. This system is known as the safety net and was created to ensure that the uninsured and the indigent have access to necessary medical services.

As more people have become uninsured, safety net responsibilities have increased. The private sector has traditionally not provided health care to persons who have no or limited ability to pay for the services. Data from the Department of Public Health indicates that 71,000 uninsured patients were seen at its facilities in the past year. This means that one-half of all uninsured patients rely on the public safety net system for either routine or episodic care. The remaining uninsured may go to other safety net providers in the City, private physician's offices (self-pay) or simply do not get care at all

Funding for safety net providers is limited -- coming from a patchwork of federal, state and local government resources (such as Medicaid, Medicare, disproportionate share payments, Proposition 99, Realignment -- sales tax and vehicle licensing fees). This patchwork of funding is generally allocated in a categorical manner. Certain funds are designated for specific groups (such as pregnant women, low-income children, persons with HIV/AIDS, etc.), certain medical conditions (e.g., mental health), certain

modalities of care (e.g., inpatient services) or certain types of providers (e.g., rural health clinics, disproportionate share hospitals).

Categorical funding was initially conceived as a way to ensure that funds would be set aside for vulnerable populations. However, as the needs of populations have become more multi-disciplinary, categorical funding has hampered the ability of providers to efficiently use funds to address the multiple needs of patients. Furthermore, even these funding sources are in constant jeopardy by federal budget proposals to reduce Medicaid and Medicare expenditures. Any reduction can compromise the CCSF's ability to continue providing services to the indigent. Finally, the proliferation of managed care financing and reduced employer-supported health coverage adds additional pressure to an already challenged safety net system.

IV. EXTENDING HEALTH CARE COVERAGE TO THE UNINSURED -- OBJECTIVE, GOALS AND GUIDING PRINCIPLES

The principal policy objective of the Committee is to recommend an expanded health care coverage program for the uninsured. By implementing this project San Francisco can provide health care access to the uninsured who: (1) are ineligible for publicly-funded health insurance, (2) cannot afford coverage in the individual market or (3) work for employers who do not currently offer health insurance. The project involves developing a comprehensive purchasing system that provides a range of benefits including preventive primary care, acute care, mental health services, and substance abuse treatment to this population.

The Committee has followed the deliberations of President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and strongly endorses their statement regarding our health care delivery system which read as follows:

> *"The purpose of the health care system must be to continuously reduce the impact and burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States."*

We believe that this statement encapsulates a fundamental principle in expanding health insurance which is to reduce illness and injury among our residents.

A. Goals

The goals of the project are multi-faceted, reflecting the Committee's desire to not only improve access, but to also improve health status and utilize resources efficiently. Expanding health care coverage to the uninsured will achieve the following goals.

- make health insurance affordable and available to all San Francisco residents,

- define a standard, comprehensive benefits package for indigent care,
- offer choice of providers and/or health plans, thereby improving quality and
- promote preventive and primary care.

These goals effect not only the uninsured, but the San Francisco community at-large. If we can ensure the health and welfare of the uninsured population, then we can improve the health and well-being of our entire community.

B. Guiding Principles

To guide its development of a health insurance program for the uninsured, the Committee adopted a set of principles. These principles reflect the Committee's desire to ensure the availability of quality, cost-effective care to the CCSF's uninsured residents while emphasizing primary and preventive care (including public health services), choice among providers and continuity of care.[28] Below are the guiding principles adopted by the Committee:

General Principles

- Access to health care is a key factor in ensuring the quality of life in our City.
- For the most part, San Francisco employers want to provide health care to their employees, but many cannot afford to do so.
- There are many aspects of the current health care delivery system that are effective. These should be preserved and incorporated into any expanded health care plan that attempts to provide employers with an incentive to better meet San Francisco's continuing health care needs.
- Changes in the health care industry and in the configuration of public financing should be adapted to accommodate the implementation of an expanded health care plan.

[28] Residents are those who live in the City, as defined by the Board of Supervisors and the Mayor. An individual's citizenship status has no bearing on whether they would be considered a San Francisco resident for the purpose of expanded health care coverage.

- The purchasing program will be structured to promote health, and to preserve and protect services for those who are persistently and chronically ill.
- The governance structure of the purchasing program should be one that has long-term stability and allows for sufficient oversight and measurement of the program's objectives.
- Simplicity in administration and implementation will be emphasized, in order to reduce both administrative cost and start-up time, and to maintain short and long term viability.

Emphasis on Primary and Preventive Care

- Health care is enhanced by the development of a continuous relationship between a patient and his/her primary care provider.
- Most health care services are best provided at the primary care level.

Choice

- Members enrolled in the purchasing program should have a reasonable choice of both primary care providers, clinics or other facilities, and health plans.
- Choice can be made available through a choice of plans, provider groups or both.
- Participants should have information made available to them that allows for effective exercise of choice, including assessments of consumer satisfaction, quality of care and other measures.

Benefit Package

- The benefit package provided to participants should seek to emphasize continuity of care, and focus on prevention and primary care services (including public health).
- In order to avoid crowd-out, the cost and scope of the basic benefit package must be comparable to that provided in the private market. The package must be structured to encourage participation by employers, with the goal of increasing

the number of employers who offer health insurance to their employees and thereby decreasing the number of persons without health insurance.

- in order to assure that participants are treated in a coordinated fashion, specialty services, including behavioral care, should be integrated into the benefit package as much as possible.
- Planning for inclusion of long-term care services will be deferred to the CCSF's Long-Term Care Pilot Project Task Force.

Cost of Package

- The purchasing program should seek the best value for the most coverage.
- The package should be priced to encourage the best use of health care resources.
- The benefits package should be structured to minimize duplication of resources and administrative costs.
- The CCSF shall continue to seek to maximize state and federal funds for all low-income, vulnerable or needy populations.

Timing

- The purchasing program will be phased-in. However, initial implementation should, at a minimum, focus on a subset of those that are currently uninsured.
- The administrative structure should seek to minimize the time needed for start-up and for state or federal plan approvals, if any are necessary.

V. POLICY ISSUES INVOLVED IN EXTENDING COVERAGE

Over the past several months, the Committee has gained a better appreciation of the factors that impact the design of a health insurance program. The program must simultaneously respond to access and health care service needs of the uninsured, create financial incentives for business to participate and develop a viable, cost-effective administrative structure.

The Committee has identified five factors that must be considered when designing a quality health insurance program:

- affordability,
- perceived need for health insurance,
- mandatory versus voluntary participation, with incentives to participate,
- maintaining and/or expanding private sector participation and
- maintaining and/or expanding public sector participation.

A. Affordability

First and foremost, the program must be affordable if it is to be attractive to employers and enrollees. This constraint automatically establishes boundaries on how expansive the scope of benefits under any program can be. As the scope of services increases, so does the cost of the program. If the cost of the program is seen as prohibitive, then few will enroll in it. Cost is the primary reason given by smaller employers as to why they do not offer coverage and by the uninsured who do not purchase coverage on the individual market.

Any person or entity conducting business in the CCSF must register and is subject to paying either a payroll expense tax or a business tax, whichever is higher. Businesses with taxes under $2,500 a year are exempt from either tax but must pay the CCSF's

business registration fee ($25). These are generally small businesses with perhaps two to six employees.

San Francisco tax data indicate that 54,792 firms paid payroll taxes in 1995 (the most recent year for available data). Of these, 31% (16,931 firms) employed one to ten employees and 58% (31,967 firms) were registered as self-employed individuals with no employees. In 1996, 7,119 businesses paid the business tax. Of those, 64% were small and medium sized businesses with a tax liability of $2,500 to $10,000. This information indicates that San Francisco has a large number of small businesses and self-employed persons. These firms may or may not office health insurance based on the cost.

Employers usually require employees to contribute some portion to the cost of health insurance. The ability of employees to accept the coverage offered will depend upon their salary, their ability to receive health insurance under their spouse's or domestic partner's coverage and their family size. As previously noted in Section II of this report, low-wage employees decline health care coverage at higher rates than high-wage employees. As a result, any purchasing program must take into account the financial circumstances of both the employers and employees.

Finally, the program must understand the financial resources of the CCSF. This is particularly important since through this program the CCSF will be funding a portion of the health care costs of residents who are Section 17000 obligations (i.e., indigent) and those who are working uninsured.[29]

[29] California Welfare and Institutions Code Section 17000 obligates counties to "relieve and support" persons who do not have the financial resources to provide for their own care. The Section 17000 population typically includes citizens and non-citizens who are part-time employees, college students, the unemployed, general assistance recipients and full-time workers with employers who do not provide medical coverage.

B. Perceived Need for Health Insurance

Second, the Committee realizes that there are different perceptions regarding the value of health care coverage. Persons 19 - 34 years of age are more likely to be uninsured. People in this age group may be full-time, part-time or flex workers, and/or full or part-time students. Younger people may have a different perspective on health insurance. They are relatively healthy and may perceive their risk of illness (catastrophic or otherwise) to be quite low. If they are in entry-level or low-wage jobs, they may actively choose not to pay for health care insurance and use their income for other purposes. Young adults may also carry significant school or other debt which impacts their willingness and ability to pay for health insurance.

In addition, as mentioned earlier, some uninsured may not equate health insurance to health care. As a result, they may not see the importance of health insurance to receiving care. This is particularly true if an uninsured person is able to access care when they need it on an urgent and/or emergency basis.

For many years, our nation's health insurance has been based on an employment model -- if you are employed health insurance coverage is available if your employer offers coverage for yourself and your dependents. Many employers may no longer feel a responsibility for bearing all or a majority of the cost of employee health care coverage. Some employers offer employees the option of accepting additional cash compensation in exchange for receiving health care benefits whether or not the worker has access to coverage elsewhere.

C. Mandatory versus Voluntary Participation

Third, the Committee has explored the advantages, disadvantages and implementation requirements of a mandatory versus voluntary program. A program which required all employers to purchase health care for their employees or all San Francisco residents to have health insurance would achieve the CCSF's goal of having universal health care.

However, due to federal restrictions a mandatory program cannot be implemented. In addition, from a competitive economic standpoint, a mandatory program is potentially problematic for some employers. No local health care reform policy should force employers to close or move their business.

The federal Employee Retirement Income Security Act (ERISA) governs the activities of all employment-based health and pension plans. ERISA covers over 2.5 million private sector health plans which provide health insurance to almost 125 million people. Most workers and their dependents receive health care through ERISA-covered health plans. In an effort to create uniform standards among health and pension plans, all employee benefits plans covered under ERISA are subject to federal regulation, but not direct state regulation. States and localities are preempted from regulating ERISA plans. ERISA effectively prevents the CCSF from requiring employers to provide health insurance.

In addition, there are no laws which require employees to accept health care insurance that is offered by their employer. Nor is there anything that requires individuals to purchase health insurance for themselves. Health insurance is not like automobile insurance -- society seems to believe that if you decide not to have or cannot afford health insurance then you are only putting yourself at risk, and not others. Yet, taxpayers ultimately pay the cost when the uninsured develop high cost medical problems or when an uninsured person becomes prematurely disabled. Once these situations occur, the uninsured have greater difficulty obtaining coverage due to exclusionary medical underwriting practices.

Given these realities, the Committee is proposing an aggressive, but strictly voluntary program -- no resident or employer would be required to participate in the expanded health insurance program. The voluntary nature of the program means that some residents will remain uninsured and that universal health care coverage will continue to be a goal. Some people may simply not be interested in heath insurance no matter how

inexpensive or how many services are provided. A voluntary program will require more extensive outreach and education. This will be necessary to attract employers and residents to the program. The Committee strongly believes that insurance brokers are key to effectively obtaining business interest and participation. Brokers understand the health insurance market from both the consumer and purchaser perspective.

D. Maintaining and/or Expanding Private Sector Participation

The Committee wants to ensure that this new purchasing program does not reduce private sector investment in health care coverage. There is the concern that some employers and individuals might substitute their current insurance for partially-subsidized, public insurance when it becomes available. There is also the concern that some employers would simply stop offering health care insurance or reduce their contribution towards the cost of health care.

This phenomenon is known as "crowd-out." It refers to situations in which persons with private insurance join public insurance programs, crowding out persons with no coverage for which the public program was designed. Crowd out is perceived to be more of a problem when publicly-supported health insurance programs allow middle-income households to participate.[30] In designing this purchasing program, there is a delicate balance between eligibility, size of enrollment, actuarial risk, scope of services and cost. These factors cannot be so attractive to employers that they drop their existing health care coverage plans to enroll in a new partially-subsidized program.

E. Maintaining and/or Expanding Public Sector Participation

Lastly, the Committee does not want this purchasing program to disqualify or create a disincentive for people to apply for Medi-Cal, Medicare, Health Families or any other

[30] Deborah Chollet, Michael Birnbaum and Michael Sherman, "Deterring Crowd-out in Public Insurance Programs State Policies and Experience." Alpha Center, October 1997

publicly-funded health insurance program for which they are eligible. It is critical that the uninsured continue to apply for and enroll in these programs whenever eligible.

VI. PROPOSED MULTI-PAYOR HEALTH CARE MODEL

Developing an appropriate health insurance program required the Committee to examine the following issues:

- eligibility: which individuals will be eligible for participation,
- scope of benefits: what health care services will be provided,
- health plans: which networks of providers (doctors, clinics and hospitals) will serve the population,
- financing: what level of funding (along with the sources of funding) is needed to extend health care coverage to the uninsured,
- governance: what governance structure is necessary to ensure that the program's mission is being effectively carried out.

The Committee is recommending a model which will meet the CCSF's strategic goal of reducing the number of uninsured residents while simultaneously adhering to the principles laid forth in Section IV. Several potential models were explored by the Committee; they ranged from having the CCSF provide services directly to the uninsured to contracting with another entity (e.g., an existing purchasing alliance). The Committee believes that a private-public purchasing program will most efficiently meet the CCSF's goals.

A. Purchasing Program

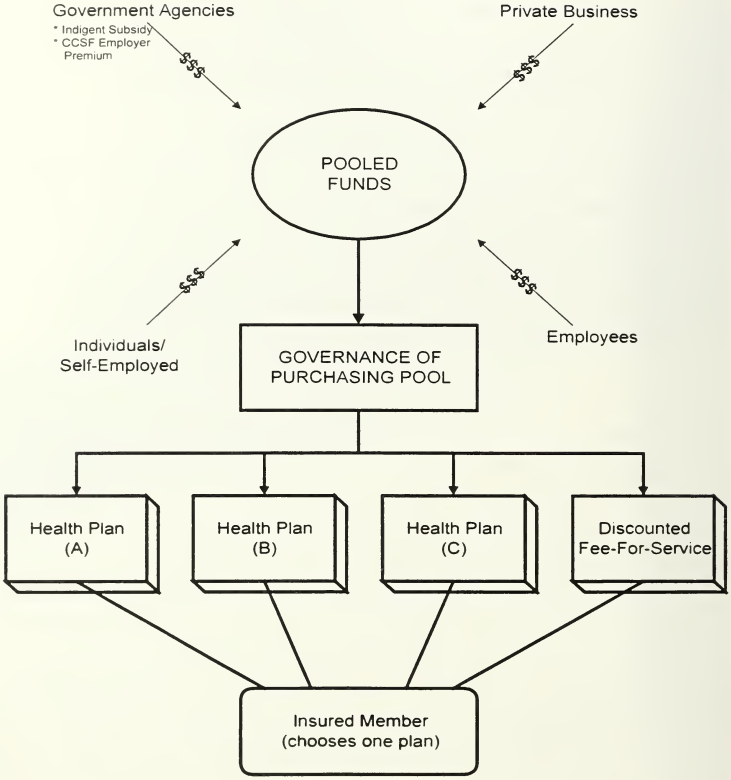
The proposed model for extending health care coverage to the uninsured relies on a purchasing alliance/pool. Under this model, health care funds are pooled from a variety of sources (employers, public agencies and members) in order to leverage purchasing power, contain premium costs, enhance choice, improve quality and reduce administrative costs. Under this method, health care services would be purchased from health plans on behalf of the enrolled population.

The Committee has identified the following advantages to creating a purchasing alliance model to expand health care coverage:

- increases the provision of comprehensive preventive and primary care,
- allows for voluntary participation,
- prevents insurers from screening out certain individuals,
- uses market competition -- broad provider networks to increase consumer choice,
- pools funding from different sources and
- achieves reasonable premiums through leveraging and negotiations.

On the following page is a graphical representation of the proposed model.

PROPOSED PURCHASING PROGRAM



In developing its model, the Committee looked closely at several purchasing alliances in California with particular attention paid to the Health Insurance Plan of California (HIPC). HIPC enables small firms (those with 2 to 50 employees) to more economically purchase health care coverage through volume purchasing. HIPC is entirely voluntary and is based on a managed competition model. The missions of the Committee and HIPC are clearly similar. Both appreciate the difficulty that employers have had purchasing health care coverage and want to assist them in making health insurance more affordable. The two striking differences between the Committee's work and HIPC is that the Committee will offer coverage to self-employed, non-working adults, students, part-time workers and undocumented persons, and will propose a CCSF subsidy for eligible low-income workers. This restructuring of indigent care can create subsidies which simultaneously allow for expanded choice and strengthen the program's purchasing power on behalf of all participating employers.

As of April 1998, 7,415 employer groups participated in HIPC and obtained health insurance for 136,658 employees and their dependents. In order to purchase health insurance under HIPC, a small firm must meet the following criteria:

- employ 2 to 50 full-time employees (i.e., 30 hours a week or more)
- contribute at least 50% of the premium cost for employees
- for employer contributions less than 100%, at least 70% of employees must participate and
- cover 100% of Workers' Compensation costs for eligible employees.

An employee cannot participate on his/her own in HIPC; they must enroll through an employer.

San Francisco's HIPC participation and demographic profile is as follows [31]

- roughly 7,000 employees and their dependents are enrolled in HIPC (1% of San Francisco's population),

[31] Health Insurance Plan of California, September 1997

- average length of stay for HIPC is two years,
- average number of employees in small businesses participating in HIPC is 10,
- almost 32% of the San Francisco firms are in finance, insurance or real estate, 17% are in manufacturing and 16.5% are in wholesale and retail trade,
- 28.2% of enrollees are under 30 years of age, 35.5% are 30 - 39 years of age, 24.5% are 40 -49 years of age and 11.8% are 50 years of age and older,
- 43% of the enrollees are women and 57% are men and
- 52% of enrollees are Caucasian and 48% are people of color.

The majority of firms that join HIPC are businesses that currently provide health care but join HIPC because the cost of purchasing care under HIPC is less than the cost of purchasing coverage under their current arrangement. As a result, there is the concern that HIPC has not been as successful insuring the uninsured. In April 1998, the percentage of employers that had previously not provided health care coverage to their employees before joining HIPC was approximately 28%. This may be due to several factors, including marketing, the lack of public subsidy for the program, or the program's public, governmental status. HIPC is in the process of being privatized, as required by State statute. Privatization may make the HIPC more attractive to businesses which are generally leery of government-administered programs.

In addition to HIPC, there are five other purchasing alliances in the State. They are:

- California Public Employees Retirement System (CalPERS): purchases health insurance on behalf of almost 1,000,000 California public employees, retirees and dependents,
- Pacific Business Group on Health: negotiating alliance that represents large private employers (those with over 2,000 employees),
- Benefits Alliance: purchasing group for mid-sized employers (firms with 51 employers or more),
- California Choice: for-profit marketing cooperative for small employers and

- Healthy Families Program: state-run pool for children in families with incomes between 100% and 200% of FPL (effective July 1998).

In 1996, the State enacted the Private Health Care Voluntary Purchasing Alliance Act (SB 1559).[32] This Act is intended to improve competition in the pricing and delivering of health care coverage for employers, specifically, small employers. It authorizes the formation of private competing purchasing alliances by individuals, partnerships, corporations or trusts through which eligible employers can purchase health care coverage. Under SB 1559, the purchasing alliance must be registered to operate in all regions of the State. These purchasing alliances are regulated under the State Department of Insurance. Any purchasing alliance established by the CCSF may fall under the regulation of the State Department of Insurance.

Because purchasing alliances are voluntary (i.e., employers and residents are not required to participate) marketing the product is crucial. The health insurance premium and scope of benefits must be attractive to entice employers, employees and other residents to pay for it. It must also be attractive for insurance brokers to sell.

Developing and maintaining an appropriate administrative structure will be critical to the success of the proposed program. The responsibilities of the purchasing program will include distributing enrollment material, verifying enrollment eligibility, collecting and handling premiums, developing and monitoring a quality assurance program, and other functions as required under SB 1559.

B. Deterring Crowd-Out

In creating a new purchasing program for the uninsured, the Committee must reduce the potential that some people will substitute subsidized public insurance for private

[32] Appendix B is a copy of the Private Health Care Voluntary Purchasing Alliance Act (SB 1559).

insurance. This is the "crowd-out" phenomenon. Crowd-out is generally viewed as a problem if a public insurance program allows middle-income persons to be eligible. There are several indirect and direct measures to reduce crowd-out. These measures can be incorporated into the original design of the program. Indirect measures to reduce crowd out include:

- limiting enrollment based on household income,
- limiting enrollment based on assets,
- limiting enrollment based on age,
- requiring enrollees to pay premiums and
- placing limits on the scope of benefits.

Direct measures to reduce crowd-out include:

- requiring persons to be uninsured at time of enrollment,
- requiring persons to be underinsured at a certain level,
- requiring persons to be uninsured for minimum period and
- requiring proof that person cannot access private coverage.

In addressing the crowd-out issue, the Committee believes that the purchasing program will need to consider some combination of indirect and direct measures. The Committee recognizes that additional indirect or direct measures may be needed at a later date if those proposed prove to be insufficient. Crowd-out should be carefully monitored. The purchasing program will need to carefully weigh restrictions imposed on enrollment to avoid crowd-out against the need to provide an employer-friendly, un-cumbersome, eligibility and enrollment system.

C. Care Model of Service Delivery

The purchasing program will contract with managed care entities and other integrated delivery systems to provide a comprehensive scope of services. The uninsured will receive a primary care provider who is part of a larger network of providers, clinics and hospitals. This is in keeping with the general trend within the overall health care

industry. Currently, over 70% of all persons with employer-based coverage receive their care through some form of managed care system. In addition, almost 40% of the State's Medi-Cal recipients are enrolled in managed care health plans.

Key components of service delivery will be incorporated within the care model:

- continuous coverage for enrolled members over a period of time,
- selection of a primary care provider,
- primary care provider serves as the coordinator of care to ensure that enrolled members obtain appropriate and timely health care services,
- prevention, health education, early detection programs are emphasized and
- utilization management and review is established to monitor provision of care and practice patterns of providers.

D. Eligible Population

The Committee recommends that the following be eligible for the program:

- Employers: Businesses are eligible to enroll their employees into the program. The program will make great efforts to target small business owners who have difficulty affording health care coverage. Self-employer persons are also eligible.
- Working uninsured: Working uninsured will be eligible for enrollment either through their employer, or as an individual if their employer chooses not to participate. There is no minimum number of hours that the person must work to enroll in the program.
- Children above 200% of federal poverty level: These children do not have access to publicly-supported health care. Most children under 200% of the federal poverty level are eligible for either Medi-Cal or Healthy Families and therefore will not be covered through this purchasing program. If families under 200% FPL apply for health care for children under this program, then they will be referred to either the San Francisco Department of Human Services Medi-Cal Program or Healthy Families Program staff. Children below 200% of FPL who are ineligible

for Medi-Cal or Healthy Families (e.g., because of legal status) would be eligible for the purchasing program.

- College students: Low-income college students have high rates of being uninsured and will be eligible for the program.
- Non-working Uninsured adults: These individuals who have traditionally relied on safety net providers will be eligible for the purchasing program.

Once enrolled in the program, a person will have financial eligibility (based on income) re-determined quarterly. Assuming on-going eligibility, a one (1) year lock-in period into a health plan is recommended. The purchasing program will not do any medical underwriting to exclude eligible persons with pre-existing conditions from the program (i.e., there will be no "red-lining").

As the purchasing pool is developed, it may expand its eligible population to include others. For example, the Committee discussed the desirability of having the purchasing program buy care on behalf of CCSF employees at the outset. Other large employers, Medi-Cal recipients and beneficiaries needing long-term care should also be considered for participation. The Committee recognizes that in order to determine the feasibility of including any of these additional populations, more data and actuarial work will be needed.

However, the Committee strongly believes that the CCSF should consider having individuals covered by the San Francisco Health Service System enrolled in this proposed purchasing program. The Health Service System is a division of the Department of Human Resources. It provides health coverage on behalf of: (1) CCSF employees and their dependents, (2) San Francisco Unified School District employees and their dependents, (3) San Francisco Community College District employees and their dependents and (4) retirees from these three systems. The current benefit programs consist of health, dental, disability, and life insurance, as well as, medical

reimbursement programs. As of May 1997, the CCSF purchased care on behalf of 116,454 individuals.

As a large employer, the CCSF brings considerable purchasing power to any health care market. In order to leverage its purchasing position for its employees, the CCSF should have the purchasing program take over the contracting and purchasing of health care benefits for CCSF, school district and community college district employees, retirees and dependents from the Health Service System ("HSS"). The CCSF can more efficiently obtain health care benefits for its employees by leveraging the purchasing for all employers participating in the purchasing program. At full participation, 247,000 people (116,454 insured employees and 130,000 uninsured) could obtain coverage through the purchasing program. While the Committee encourages the transfer of the purchasing function for health benefits from HSS to the purchasing program, it does not presume any reductions in the benefits offered to CCSF members. This would remain a policy matter for the Mayor and Board of Supervisors. The Committee believes that the transfer of this particular function should be done consistent with the goals of reducing administrative costs to the CCSF's general fund. With these savings and/or cost avoidance, funds could be redirected to expand the proposed minimum benefits package to the uninsured (e.g., to include such services as dental, vision, etc.). The funds could also be used to strengthen supplemental services, or to make necessary infrastructure and capital improvements in the CCSF's safety net system (the Community Health Network).

E. Residency Requirement

The Committee recommends that a six (6) month residency period be instituted for working uninsured who enroll into the program without an employer. This residency requirement would apply whether or not the individual was eligible for a subsidy.

The Committee also recommends that individuals meet a six (6) month continuous residency requirement before becoming eligible for a premium subsidy. During this six (6) month period, the CCSF' safety net system would continue to fulfill its Section 17000 obligations to care for these individuals. This residency requirement does not refer to immigration status. Any documented or undocumented resident will be eligible for the program if they have resided in the CCSF for at least six months.

Beyond this residency requirement and waiting period to receive a CCSF subsidy, the Committee has not established other eligibility criteria. Given this, the Committee recommends that enrollment into this program be monitored closely to ensure that crowd-out is minimized. Some states, which have implemented health insurance programs, found that if their eligibility criteria is liberal then people who could afford health insurance enrolled in lower cost subsidized programs when given the opportunity.[33] This potential problem must be carefully monitored.

F. Scope of Benefits

During the planning process, the Committee wrestled with the trade-off between the scope of benefits in the program and the number of individuals to be covered by the program. Financial resources are not unlimited. The program can take two different approaches. It can be designed to provide a very broad range of services, but in doing so is likely to provide coverage to a much smaller number of people. Or, it can be designed to provide a standard, but comprehensive scope of services, that covers more uninsured people. The Committee chose the latter approach in keeping with the CCSF's goal of providing affordable health care coverage for all San Franciscans. The CCSF will not further its goal by offering an expansive scope of benefits that few can or will purchase even it is publicly subsidized in some manner.

[33] Audit of the QUEST Demonstration Project. State of Hawaii, Auditor, December 1996

The proposed scope of benefits on the following page is for employees of small businesses, the self-employed, individuals with no employer sponsorship and the medically indigent. It is based on a benefits package offered under the Health Insurance Plan of California. This is consistent with the Committee's principle that the "cost and scope of the basic benefits package will be comparable to that provided in the private market." The range of benefits include preventive primary care, acute care, mental health services and substance abuse treatment. The two benefits packages that are proposed for the purchasing program are as follows:

PROPOSED SCOPE OF BENEFITS FOR PURCHASING PROGRAM

Benefit Summary	Standard HMO Plan	Preferred HMO Plan
Yearly Deductible	$0	$0
Yearly-Out-of-Pocket Maximum Expense	$2,000 per person $4,000 per family	$2,000 per person $4,000 per family
Physician Services	$15 co-pay per visit	$5 co-pay per visit
Inpatient Services	$100 co-pay per admission	no charge
Hospital Outpatient Services	$15 co-pay per visit	$5 co-pay per visit
Prescription Drugs	Generic (30 day supply) -- $10 co-pay Brand (30 day supply) -- $15 co-pay Generic (90 day supply) -- $20 co-pay Brand (90 day supply) -- $30 co-pay	Generic (30 day supply) -- $5 co-pay Brand (30 day supply) -- $10 co-pay Generic (90 day supply) -- $10 co-pay Brand (90 day supply) -- $20 co-pay
Emergency Services	$50 co-pay per visit; waived if admitted	$50 co-pay per visit; waived if admitted
Preventive Services	$15 co-pay per visit	$5 co-pay per visit
Mental Health -- Inpatient	$100 co-pay per admission; limit -- 10 days per year	no charge; limit -- 20 days per year
Mental Health -- Outpatient	$20 co-pay per visit; limit -- 20 visits per year	$20 co-pay per visit; limit -- 20 visits per year
Chemical Dependency -- Inpatient (detoxification only)	$100 co-pay per admission	no charge
Chemical Dependency -- Outpatient	maximum payment of $20 per day; limited to $400 per year	maximum payment of $20 per day; limited to $400 per year
Durable Medical Equipment	no charge	no charge
Home Care	$15 co-pay per visit	$5 co-pay per visit
Infertility Testing	co-pay -- 50% of contracted rate	co-pay -- 50% of contracted rate
Physical Therapy	$15 co-pay per visit up to 60-day period per condition	$5 co-pay per visit up to 60-day period per condition
Skilled Nursing Care	$100 co-pay per admission, limit 60 days per year	no charge, limit 60 days per year
Vision Care	limited to preventive care exams for minors	limited to preventive care exams for minors

The proposed benefits package was designed so that it would be comprehensive, but would not create an incentive for currently insured persons or employers to drop coverage for themselves or their employees. The Committee's goal was to minimize the potential reduction of employer-based coverage to this new purchasing program. Placing limits on the benefits package has been used to deter crowd-out.

i. Limited Services Within Benefits Package

The benefits package, while comprehensive does have limited coverage on certain benefits, namely skilled nursing care, mental health and chemical dependency services. The Committee understands that some individuals receiving care through this purchasing program require more services than are provided in the benefits package. In the case of skilled nursing care, the benefit is limited to 60 days because persons who require skilled nursing care beyond this usually become eligible for Medi-Cal which then assumes the cost of care. These individuals would be disenrolled from the purchasing program at the time that they become eligible for a government-sponsored program.

The Committee understands that some uninsured indigent and special needs consumers may have health service needs that exceed the standard benefits package and may require supplemental services. Because of this, the Committee believes that it will be important to ensure that the purchasing program has memorandums of understanding with the San Francisco Mental Health Plan and the Substance Abuse Treatment on Demand system of care.

If a person exhausts, either their mental health or substance abuse benefits, the person would be able to receive services through the Department of Public Health's Community Mental Health Services or Community Substance Abuse Services programs. Over the past two years, the CCSF has increased funding to expand substance abuse treatment to ensure that services are available when a person is ready

for treatment. Members of the purchasing program who need substance abuse services beyond the 20 outpatient visits or inpatient services other than detoxification will be able to access services through Community Substance Abuse Services. The San Francisco Mental Health Plan (which began on April 1, 1998 and is administered by the Department of Public Health) provides mental health services to all Medi-Cal and indigent persons. Any member of the purchasing program needing ongoing mental health services will be eligible to receive services from the San Francisco Mental Health Plan after using up their benefits under this program.

ii. Non-Covered Services

At this time, the recommended benefits package does not provide dental services for children or adults, or vision care for adults. The Committee recognizes the both dental and vision services are needed by the uninsured. These benefits may be added after the purchasing program has been in operation for awhile. It can then better determine the costs and benefits of expanding the benefits package to offer dental and vision. The Committee recommends that further analysis be done to determine the cost of and interest in providing both of these services. Those needing dental care or adults needing vision care will be able to access community and public providers for theses services.

iii. Carved Out Services for Certain Populations

Some uninsured persons will have either medical or behavioral disabilities that require specialized services and care coordination that cannot be provided by a health plan in this purchasing program. For these individuals, it is more appropriate to have such services "carved-out." Services are accessed by a distinct set of providers capable of addressing the person's specialized health needs. In this purchasing program, the carved-out services are:

- mental health services for the seriously mentally ill adults and seriously emotionally disturbed children and

- physical health services for children eligible for California Children's Services.

In both of the above cases, the service carve-out is appropriate because there are organized systems of providers who have the capacity and willingness to provide these specialized services. For those children eligible for California Children's Services ("CCS"), Medi-Cal will pay for all CCS-related health conditions.

G. Health Plan Providers

A guiding principle of the Committee is member choice. Members will have the opportunity to choose health plans and/or providers. A health plan will be required to have a medical group, clinics and hospital affiliation to ensure that members have access to inpatient and outpatient services. Members will select their health plan and provider; they will not be assigned to a health plan by the purchasing program.

While no recommendations have been made concerning the total number of health plans that should be offered, it is recommended that providing either two or three health plans will allow for sufficient consumer choice. The Committee makes no recommendation concerning which health plans should participate. This decision is more appropriately made during contract negotiations. The Committee envisions that a competitive contracting process will be needed to select the participating health plans.

The Committee strongly believes that the health plans should be required to enter into memoranda of understanding for traditional public health services (e.g., Tb direct observed therapy, confidential HIV testing and sexually transmitted diseases). This will ensure that the uninsured continue to have access to these services after they are enrolled in a health plan. Public health services improve health status through such activities as health promotion, prevention and education

VII. ESTIMATED COST AND PROPOSED FINANCING

Determining the potential cost of and sources for funding this program was the most difficult aspect of the Committee's work. The costs are dependent upon the assumptions made about enrollment and health care utilization. Financing this purchasing program is a delicate balance since it requires support from employers, members and the CCSF.

A. Finance Principles

The Committee developed finance principles to guide its discussions of funding for this program. The finance principles are built in the belief that:

- purchasing power is leveraged by integrating existing private and public funding streams,
- premiums and co-payments must be affordable for members and
- participating employers will pay affordable monthly contributions.

Funding of Non-Public Providers

A health care insurance product cannot be developed without access to indigent care funding.[34] This funding is necessary to care for the entire population.

- Any provider who is receiving indigent care funding would pool funds into this purchasing program.
- The purchasing program would control allocations of indigent care funding except for funding used for services excluded from the purchasing program and/or populations not enrolling in the program.

[34] Indigent care funding refers to local and state dollars allocated to provide health care services to persons who are indigent or who are uninsured. For the purposes of this analysis, this includes State Realignment, Proposition 99 Tobacco Tax Revenues and CCSF General Fund

Pooling Funds

In proposing to pool funds, it is important to understand that pooling funds can redirect funding away from the current indigent care system. Specifically, if current funding is pooled then it is no longer directly allocated to providers. There may be a redistribution of funding among providers. At this time, the following funding streams will not be pooled: Medi-Cal (fee-for-service, disproportionate share, FQHC cost-based reimbursement), mental health, Medicare, public health services, substance abuse and long-term care.

Beneficiary Premiums and/or Co-payments

Beneficiary premiums and co-payments create an incentive for appropriate utilization of services -- there is a cost to not doing this.

- Beneficiary premiums will be pooled by the purchasing program to offset the cost of providing the health care services.
- Sliding scale premiums shall be established for enrollees based on a person's income.
- At point-of-service, a co-payment will be assessed on all enrollees but protocols for waiving the co-payment based on income level and type of services used could be established. Co-payments should be affordable and should not deter preventive care.
- Co-payments will be retained by provider.
- A reduced premium and/or co-pay could be established for enrollees that select safety net providers.

Employer and Business Funding

Explore local financial incentives for San Francisco businesses to participate.

- Participating employers will be required to pay monthly contributions, if they participate. Participation in the purchasing program is not mandatory.

Risk-Sharing (Actuarial Risk/Insurance Risk)

Risk sharing will be tied to utilization.

- Utilization: Risk will be shared between HMO and providers based on their contract agreements.
- Utilization: Given diverse eligible population, risk adjustment is needed to avoid adverse selection. Risk adjustment will occur at the health plan level.
- The purchasing program will not be a risk-bearing entity (i.e., no Knox-Keene license needed).

Enrollment

If the actual experience does not match projections on enrollment (over-enrollment), financial uncertainty for the purchasing program will be inevitable.

- Enrollment: Risk is at the purchasing program level.
- Enrollment: Cost would be shared by health plans, the business community and the CCSF.

B. Estimated Premium Cost

With grant funding from the California HealthCare Foundation, an actuarial consulting firm was retained to assist the Committee in developing cost estimates, and in making recommendations about program design and cost controls.[35]

Two actuarial approaches were taken for this analysis. The first was a *top-down* analysis that compared the current market premium rates for governmental health maintenance organization programs offered in the State. With this analysis, a market-based premium rate was derived using the proposed health benefits packages. The second approach, which is called a *bottom-up* analysis, utilized traditional actuarial methods and relied on utilization and cost assumptions to derive an appropriate per member per

[35] The cost estimates were performed by Joan Trauner and Colleen Thilgen of PM Squared, Inc. of San Francisco. A more detailed summary of the actuarial analysis can be found in Appendix C.

month rate. The rates were modeled under two benefits packages: the Health Insurance Plan of California HMO Standard and the Health Insurance Plan of California HMO Preferred benefits packages as described in Section VI.

As part of its analysis, the actuarial consultant developed cost scenarios under the following conditions:

- having a benefit package with and without inpatient hospital services,
- instituting individual annual stop-loss limits,
- changing the distribution of the number of uninsured adults versus children,
- differing employer premium contribution and member premium contribution levels and
- varying assumptions about the percentage of the uninsured population that is employed.

Tables 5 and 6 on page 55 provide the computed cost estimates. The cost estimates were derived using the following:

- Total number of uninsured 130,000
- Assumed number of adults 117,000 (90%)
- Assumed number of children 13,000 (10%)
- Assumed percentage of employed adults 75%

Under these assumptions, the total program costs range from $171.1 million to $217.2 million, depending upon the level of employer and member premiums, and whether stop loss provisions are put into place. It is important to note that these costs estimates are based on all estimated 130,000 uninsured residents enrolling into the purchasing program. While this clearly preferable, the Committee recognizes that this is may not occur given that enrollment into the program is voluntary. The Committee has not made an assumption that all 130,000 uninsured residents will be enrolled into the program. However, the Committee felt that it was important to provide the total costs

of the purchasing program with full enrollment. If fewer uninsured enroll into the purchasing program, then total annual costs (as well as uncovered annual costs) will decrease.

The computed per member per month cost (i.e., the monthly premium cost for each individual enrolled in the purchasing program) ranges from $110 to $139 and is well within health care industry standards. This per member per month cost is within the price ranges for both standard and preferred benefits packages offered by the Health Insurance Plan of California in the San Francisco Bay Area.

The current cost estimates assume an administrative cost of 15%. By comparison, the HIPC runs its state-wide program with an administrative rate of approximately 5%. Administrative costs include such activities as enrollment and disenrollment, contracting with health plans, outreach and education, collecting and tracking premiums and other functions. However, the Committee's proposal includes administrative functions that are not performed by HIPC, such as means testing for member to determine their eligibility for a subsidy. Nevertheless, the Committee believes that the level of administrative overhead factored into the purchasing program should be re-examined. The Committee wants to ensure that the highest percentage of any dollar is allocated to patient care and not to administrative expense.

TABLE 5

Health Insurance Plan of California -- PREFERRED ($5 Co-payment)

	w/o Annual Stop Loss			*w/ $30,000 Stop Loss (0.60% of Members)*		
	PMPM Cost	Total Annual Cost	Annual Uncovered Cost of Benefit	PMPM Cost	Total Annual Cost	Annual Uncovered Cost of Benefit
Employer Premium & Member Premium 20%	$139.24	$217,214,816	$152,050,371	$127.24	$198,499,685	n/a
Employer Premium & Member Premium 25%	$139.24	$217,214,816	$135,759,260	$127.24	$198,499,685	n/a
Employer Premium 30% Member Premium 20%	$139.24	$217,214,816	$135,759,260	$127.24	$198,499,685	$124,062,303
Employer Premium 30% Member Premium 25%	$139.24	$217,214,816	$127,613,704	$127.24	$198,499,685	$116,618,565
Employer Premium 40% Member Premium 20%	$139.24	$217,214,816	$119,468,149	$127.24	$198,499,685	$109,174,827
Employer Premium 40% Member Premium 25%	$139.24	$217,214,816	$111,322,593	$127.24	$198,499,685	$101,731,089
Employer Premium 50% Member Premium 20%	$139.24	$217,214,816	$103,177,038	$127.24	$198,499,685	$94,287,350
Employer Premium 50% Member Premium 25%	$139.24	$217,214,816	$95,031,482	$127.24	$198,499,685	$86,843,612

TABLE 6

Health Insurance Plan of California -- STANDARD ($15 Co-payment)

	w/o Annual Stop Loss			*w/ $30,000 Stop Loss (0.60% of Members)*		
	PM Cost to Plan	Total Annual Cost	Annual Uncovered Cost of Benefit	PM Cost to Plan	Total Annual Cost	Annual Uncovered Cost of Benefit
Employer Premium & Member Premium 20%	$120.03	$187,254,152	$131,077,906	$109.69	$171,120,418	$119,784,293
Employer Premium & Member Premium 25%	$120.03	$187,254,152	$117,033,845	$109.69	$171,120,418	$106,950,261
Employer Premium 30% Member Premium 20%	**$120.03**	**$187,254,152**	**$117,033,845**	**$109.69**	**$171,120,418**	**$106,950,261**
Employer Premium 30% Member Premium 25%	**$120.03**	**$187,254,152**	**$110,011,814**	**$109.69**	**$171,120,418**	**$100,533,246**
Employer Premium 40% Member Premium 20%	$120.03	$187,254,152	$102,989,793	$109.69	$171,120,418	$94,116,230
Employer Premium 40% Member Premium 25%	$120.03	$187,254,152	$95,967,753	$109.69	$171,120,418	$87,699,214
Employer Premium 50% Member Premium 20%	**$120.03**	**$187,254,152**	**$88,945,722**	**$109.69**	**$171,120,418**	**$81,282,199**
Employer Premium 50% Member Premium 25%	**$120.03**	**$187,254,152**	**$81,923,691**	**$109.69**	**$171,120,418**	**$74,885,183**

The annual uncovered cost (i.e., needed CCSF subsidy) is highly variable and sensitive to assumptions pertaining to the actual number of uninsured, the distribution of working uninsured to non-working uninsured, the member subsidy and other key issues. The annual uncovered cost decreases as the employer and member contribution rises. The imposition of an annual cap on health care losses per member (i.e., stop loss) also decreases the annual uncovered cost. If the stop-loss is used, the provision of care for those exceeding the stop-loss limit in any particular year would revert to the CCSF's Department of Public Health safety net system.

The fundamental tradeoff between the HIPC preferred and HIPC standard benefit packages is one of establishing reasonably affordable co-payments for members versus lowering the uncovered cost of the program. Under HIPC preferred the co-payment level is $5 per visit and $15 per visit under HIPC Standard. Recognizing that a number of the uninsured are low-income with little discretionary income, the Committee is committed to keeping co-payments as affordable as possible. In marketing the program, potential members will be particularly interested in knowing what their out-of-pocket expenses will be. However, implementing the program with a smaller co-payment level increases the overall cost of the program. This is because instead of providers being able to cover a higher portion of their costs through co-payments, the dollars must be allocated to them in the capitation rate.

As the table indicates, with no annual stop loss provision, an employer contribution of 50% and employee contribution of 25%, the county subsidy is $95 million under HIPC Preferred, but $82 million under HIPC Standard. Under HIPC Preferred the per member per month premium cost is $139.24 while under HIPC Standard it is $120.03 ($19 less). The Committee recommends that the purchasing program offer the HIPC Preferred benefits package with a $5 co-payment. It is also recommended that the employer contribution be no less than 50% (for full-time employees) and that the member premium be set at 25% (this may vary based on household income). Under

these conditions, the total annual CCSF subsidy needed to provide health care coverage to all 130,000 uninsured residents is approximately $95 million. The CCSF subsidy would be less if fewer individuals needing subsidies enrolled in the purchasing program.

C. Proposed Financing

A fundamental premise of the suggested purchasing program is that it not be financed by one single payor source. This initiative will require funding from three sources:

- employer contributions to premiums,
- member premiums and co-payments, and
- a government subsidy, when needed, for enrollees based on their income.

A critical component in funding this program will be developing mechanisms that allow for flexibility in pooling dollars -- employer contributions, member contributions and public funds.

Since there is a direct correlation between a person's income and whether they have health insurance, a subsidy will be needed to make health insurance more affordable for low-income individuals. In order to deter crowd-out, however, the subsidy cannot be too generous (i.e., result in employers paying substantially less through this purchasing program than they would through an existing private health insurance carrier). If the program results in employers paying a very low portion of the health care premium, then a more than projected number of employers may sign up for the program. If the number of enrollees who qualify for a subsidy is seriously underestimated, then the CCSF costs could exceed those budgeted for the program. In such a case, enrollment into the program would have to be stagger.

i. Employer and Member Contributions

Because the program is voluntary, its success will be dependent upon attracting employers and residents who believe that health care coverage is worthwhile, but

currently unaffordable. The purchasing program induces employers and employees to participate by lowering their costs of health care coverage. The mechanisms are:

- employers: allows them to participate in a purchasing pool so that their employer contributions can be leveraged to obtain lower health care premiums and
- individuals: provides a subsidy to those under 300% of the federal poverty level to make health care more affordable.

Because not all residents have the same value or need for health care, or live under the same financial conditions, structuring an appropriate subsidy level is difficult. This is further complicated by the fact that there has been little research done on what is a reasonable level of contribution to expect from a household for health insurance. The member premium level can be dependent upon family income, household size and cost of living.

The uninsured may become enrolled in the program in two ways: through their employer or by individually signing up. Tables 7 and 8 show the recommended Contribution Schedules (CS) for the purchasing program. In Table 8, the monthly premiums represent the cost for each individual enrolled in the program.

Table 7[36]

Contribution Schedule Based on Percentage of Premium Paid

Payor	CS1 SF Resident Income > 300% Not Enrolling Through Employer	CS2 SF Resident Income < 300% Not Enrolling Through Employer	CS3 SF Resident Income < 300% Enrolls Through Employer	CS4 SF Resident Income > 300% Enrolls Through Employer	CS5 SF Resident Indigent Under W&I Section 17000	CS6 Non-SF Resident Enrolls Through Employer
Employer Premium	0%	0%	0-15hrs = 0% 15-30hrs=25% 30+hrs=50%	50%	0%	50%
Member Premium	100%	0-99%=0% 100-199%=25% 200-299%=50%	0-15hrs=0% 15-30hrs=25% 30+hrs= 25%	50%	0%	50%
CCSF Subsidy	0%	0-99% =100% 100-199%=75% 200-299%=50%	0-15hrs=100% 15-30hrs=50% 30+hrs=25%	0%	100%	0%

Table 8

Contribution Schedule Based on Monthly Premium Cost

(HIPC Preferred -- $5 Co-Payment)

Payor	CS1 SF Resident Income > 300% Not Enrolling Through Employer	CS2 SF Resident Income < 300% Not Enrolling Through Employer	CS3 SF Resident Income < 300% Enrolls Through Employer	CS4 SF Resident Income > 300% Enrolls Through Employer	CS5 SF Resident Indigent Under W&I Section 17000	CS6 Non-SF Resident Enrolls Through Employer
Employer Premium	$0	$0	0-15hrs=$0 15-30hrs=$34.81 30+hrs=$69.62	$69.62	$0	$69.62
Member Premium	$139.24	0-99%=$0 100-199%=$34.81 200-299%=$69.62	0-15hrs=$0 15-30hrs=$34.81 30+hrs=$34.81	$69.62	$0	$69.62
CCSF Subsidy	$0	0-99% =$139.24 100-199%=$104.43 200-299%=$69.62	0-15hrs=$139.24 15-30hrs=$69.62 30+hrs=$34.81	$0	$139.24	$0

The general features of the schedules are the following:

- Persons under 300% of poverty receive a subsidy: Recognizing that low-income persons have limited disposable income, contributions for members will be tied

[36] For the purposes of the example, in CS3, assume that a person working zero (0) to 15 hours per week is under 100% FPL and that a person working 15 - 30 hours a week is between 100% FPL and 200% FPL

to their household income. As a person's income rises, they pay a higher share of the monthly premium. The income level takes family size into account. Persons/families with household income under of the 300% federal poverty level (FPL) would receive a CCSF subsidy. Indigent persons with no financial resources would not be required to pay either monthly premiums or co-payments for visits. No CCSF subsidy is available for persons/families with household income over 300% of the FPL. This is to address potential crowd-out effects among middle-income persons. Someone with household income over 300% of the federal poverty level could enroll in the purchasing program, but the total premium would be paid by the employer and/or employee.

- Employer contribution will be 50% for full-time employees (i.e., those working more than 30 hours per week): This is similar to the contribution requirement for the Health Insurance Plan of California (HIPC) which requires a minimum 50% premium contribution from the employers. The Committee felt that it was important to structure a contribution system that did not directly compete with the HIPC, but would still be more affordable.
- No subsidy for persons who work in San Francisco but live in another county: Individuals who work in San Francisco, but live in a neighboring county would be eligible to enroll in the program. The six-month residency requirement would not apply to these workers. However, they would not be eligible for a subsidy. This is to ensure that the CCSF's subsidy supports San Francisco residents. This provision could potentially have the effect of enticing businesses to hire San Francisco residents since the cost of providing health care to their San Francisco employees (within a certain income level) would be less expensive than providing coverage to employees who live from outside San Francisco. Persons who live in another county and then move to San Francisco could be eligible for a subsidy after residing in the CCSF for six months if they meet the means testing standard. The Committee does not believe that subsidies alone will entice low-

wage workers to move into San Francisco given the other cost of living considerations.

- County subsidy is targeted to the most needy: The County subsidy is structured to provide increased financial support those with no or limited resources.

Table 7 should be read in the following manner. Assume that an uninsured, 19 year old student at City College is interested in obtaining health care coverage. She works 12 hours a week for a small employer who is going to participate in the purchasing pool. However, because the student works under 15 hours per week, her employer pays no part of the premium (see CS3 above). The student is able to join the program as an individual under Contribution Schedule Number 2 where her income will determine how much her monthly premium will be. She makes $6.00 an hour (California's minimum wage became $5.75 on March 1, 1998). This puts her yearly income at $3,600 ($6/hr X 12 week X 50 weeks). This is well below the 100% federal poverty level of $8,050. As a result, CS2 shows that her entire premium would be paid for through a CCSF subsidy.

Another example would be a small employer with five employees, all of whom work 40 hours a week. All employees have incomes under 300% FPL. One employee resides in Alameda County. The contribution schedule (see CS3) indicates that the employer would pay 50% of the premium cost. For the four employees who lives in San Francisco, each would pay 25% of the premium cost and the CCSF subsidy would pay the remaining 25% (see CS3). The employee who resides in Alameda County would not be eligible for a CCSF subsidy and would, therefore, be required to pay 50% of the premium costs (see CS6).

ii. CCSF Subsidy/Indigent Care Funding

In order to increase the number of residents who have health care coverage subsidizing the cost will be necessary.

The Committee explored the possibility of imposing a new tax to fund this purchasing program. While the CCSF could increase the business tax and dedicate the proceeds to health care coverage, it would need voter approval. Since passage of Proposition 13 and most recently with passage of Proposition 218, counties are severely limited in their ability to increase taxes. Under Proposition 218, increases to existing taxes must be approved by the voters. Under California law, general taxes must pass with 50% of the votes and special purpose taxes must pass with 67% of the votes. A business tax specifying that the revenues go to support health care insurance would require a 67% passage rate which is often difficult to secure. If the business tax were increased for general purposes with the intent of having the revenues go to health insurance, then only 50% of the voters must approve it. However, because it is a general tax there would be no guarantee that the revenues would be used on health care coverage. More importantly, it is unclear whether more local tax dollars are actually needed to implement the program as designed. If all employers would voluntarily participate in this, or a comparable program (i.e., HIPC), new general taxes would likely not be needed.

The Committee also explored the use of tax credits to financially incentivize employers to participate. However, implementing a business tax credit (i.e., provide businesses with a reduction in tax liability if they join the health insurance purchasing program) in many ways is tantamount to changing tax rates. Business tax credits are essentially reductions in a firm's tax liability. A tax credit would only be attractive to firms that were paying either the CCSF's payroll tax or the business tax. Small businesses with tax liability under $2,500 are only required to pay a business registration fee of $25 and therefore would not be affected by this financial incentive. A business tax credit would also reduce the CCSF revenues. As a result, further analysis would be needed to determine the policy and fiscal impact of creating such a tax credit

The CCSF currently receives federal and State funding, and allocates General Fund dollars for indigent care.[37] These funds are currently allocated to the San Francisco Department of Public Health to provide primary care, emergency care and hospitalization for those who have no ability to pay for health services.

In total, $90.7 million has been identified as funding currently used to provide physical health care to uninsured indigents in San Francisco. These funds are used to enable the CCSF to meet its California Welfare and Institutions Code Section 17000 obligation to ensure health care services to the indigent. The Committee has not included Medi-Cal funding as a potential funding source because, at this time, the purchasing program will not be enrolling Medi-Cal beneficiaries. The Committee has deferred recommending enrollment of this population pending the outcome of on-going Medicaid planning efforts (i.e., the Medicaid 1115 waiver demonstration project and the County-Organized Health System). If a decision is made at a later date to enroll Medi-Cal beneficiaries into this purchasing program, then Medi-Cal funding could be pooled into the program.

Table 9 on the following page shows the current indigent care funding.

[37] For the purposes of the Committee's work, indigent care funding includes State Realignment, Proposition 99 funds and CCSF general fund dollars.

TABLE 9

Source	Amount	Funding Description and Current Use
CCSF General Fund	$32.4 million	This represents 20% of the Department of Public Health's 1997-98 allocation. These funds are currently allocated to the primary care clinics and San Francisco General Hospital.
State Realignment	$49.2 million	Transferred State sales tax and vehicle license fee funds to care for the uninsured. These funds are currently allocated to the primary care clinics and San Francisco General Hospital.
Proposition 99	$9.1 million	California voter initiative that established a 25 cents increase in the tobacco tax to fund care for the uninsured. These funds are currently allocated to San Francisco General Hospital, and other providers and hospitals within the City
Total: Indigent Care Funds	$90.7 million	

The Committee has provided this synopsis of the indigent care funding with the understanding that all of these funds may not be available for the purchasing program. The Committee assumes a certain level of indigent care funding will still be needed for CCSF's safety net system to care for individuals: (1) who are not enrolled in the purchasing program, (2) who are enrolled in the purchasing program, but need to access supplemental services from the safety net or (3) who must access carved-out services.

VIII. PROPOSED GOVERNANCE STRUCTURE

In order to fully implement any proposed purchasing program to expand health care coverage to the uninsured, a governing body is needed. The governing body is necessary to ensure overall oversight of the purchasing program.

The purchasing program will be created by State land/or San Francisco Board of Supervisors legislation. It will be a separate legal entity from the CCSF. The purchasing program would be a separate non-profit public benefits corporation, unless further research indicates that another governance structure would be more advantageous.

A. Governing Body Responsibility And Role

The mission of the governing body is to ensure the availability of quality, cost-effective health care to the CCSF's uninsured residents. It will ensure that the purchasing program's mission is fulfilled and will set policies consistent with the program's mission. In order to fulfill its responsibility, the governing body will:

- Define, and as necessary, revise the purchasing program's mission to ensure that it is relevant to the changing environment.
- Establish the long-term direction of the purchasing program through strategic planning and administrative oversight.
- Determine the scope of programs and services to be provided to members.
- Maintain the financial viability and stability of the purchasing program.
- Establish programmatic and operational policies of the purchasing program.
- Promote and maintain positive external relationships with the community, local business, government, funding sources, providers and other health-related organizations.
- Establish procedures for an effective governing body, including member recruitment, training and self-evaluation.

B. Governing Body Membership

A nine member governing body is proposed. All members of the governing body shall be voting members except the San Francisco Director of Health and the San Francisco Controller.

Each governing body member must have a commitment to the health and well-being of San Franciscans and to expanding health care coverage to the uninsured, regardless of their economic condition or legal residency status. Members of the governing body should also possess a desire to improve access to quality, cost-effective care. In addition, members must have knowledge of the health care issues unique to San Francisco's uninsured residents and communities. A majority of the governing body members must be residents of San Francisco. Enrolled members (i.e., consumers) shall be represented on the governing body.

Understanding the difficult task involved in creating any purchasing program for health care coverage, it is critical that the governing board be comprised of individuals who possess a core set of skills and knowledge base. It is recognized that the governing body will change over time as the purchasing program matures. Some of the skills identified for the governing body in the initial stages of the purchasing program may be different from those that might be identified in the future. In addition to certain skills and knowledge base that should be possessed by governing body members, there may also be certain constituencies represented on the governing body given the purchasing program's mission.

The governing body should possess as a whole the following skills and knowledge base. No single governing body member is expected to have experience in all of the areas articulated below. It is the expectation that individual members will have knowledge in at least one of the specific areas and that they will bring that knowledge to assist the governing body in fulfilling its mission to oversee the purchasing program.

The governing body composition supports the complex governance issues related to administering a purchasing program. The governing body will be comprised of individuals with knowledge in:

- Purchasing Pools and/or Health Insurance Agencies: Experience in this area will be critical given the proposed design of this program. A proposed member would be evaluated based on their familiarity with and experience in either designing or managing health insurance programs. Relevant skills would include governance, planning, policy development, public relations, organizational development and management.

- Financial Management: The governing body will oversee a significant budget with multiple funding streams. The purchasing program structure will require the governing body to be financially responsible for the provision of care. It will be required to cover initial start-up and operational costs. In addition, provider reimbursement will be capitated on a per member, per month basis. Experience with budget management, managed care capitated financing, financial decision-making and public sector funding sources will be necessary to maximize funding and ensure efficient use of resources.

- Clinical Quality: A cornerstone of the purchasing program, will be providing quality care to uninsured residents. Through contractual arrangements with health plans, the purchasing program will have an opportunity to improve the quality of care received by indigent persons. The governing body should have expertise in clinical quality issues and accountability to establish measures for evaluating whether this program has assisted in improving health outcomes for this population.

- Marketing and Public Relations: This program will be based on voluntary enrollment. Time and resources must be spent on education and outreach to prospective employers, employees, self-employed individuals and the indigent. Such activities will be necessary to determine the potential enrollment (and thereby costs) for the program on an annual basis. Experience in public relations, education and outreach in attracting members to health insurance programs will be critical.

- Managed Care: As designed, the purchasing program will contract with health plans (public, non-profit and private) to deliver care to its members. The purchasing program will use managed care principles of gatekeeping, case management, quality assurance and financial risk-sharing and utilization review to deliver care to its enrolled members. Experience in implementing managed care systems in either IPAs, clinics and/or hospital settings will be desirable.

- Safety Net: The purchasing program could potentially redefine how the health care safety net is defined and who the safety net providers are. It is also recognized that even after this purchasing program is fully implemented there will be uninsured individuals who do not participate in the program. These individuals will need to receive care through a safety net system. The governing body should have expertise in safety net systems and understand their importance in meeting the health care needs of special need populations.

In addition to the governing body knowledge base listed above, the governing body will also have representation from specified constituency groups. This representation is necessary to ensure that the purchasing program recognizes the needs and interests of key stake holders and works effectively with these diverse constituencies. The following will have designated seats on the governing body:

- Enrolled Members: Representation from enrolled members ensures that coverage is provided in a manner that is responsive to their needs. It provides an opportunity for dialogue between the governing body and beneficiaries to determine innovative solutions to address concerns. In addition, member representation can help develop a broad base of community support for expanded health care coverage and can provide a specific access point for beneficiary input. In the initial stages of the program's development, before it is fully operational with enrolled members, uninsured consumers may sit on the board until an enrolled member is recruited.

- Small Business: Small businesses will play a significant role in extending health care coverage to the uninsured. Representation from small businesses will ensure that policies and programs are responsive to their needs and have their support. In addition, representation of small businesses can assist in acquiring support from the small business community for expanded health care coverage and can provide a specific access point for input from small businesses.

- Providers: Implementation of expanded health care coverage will depend on the participation of the local provider community. The experience of providers caring for uninsured residents will be critical for governance, planning and the delivery of care.

- City and County of San Francisco: This purchasing program will allow the CCSF an alternative means of meeting its Section 17000 responsibilities and the CCSF will potentially contribute a significant portion of funds to this program. Representation from the CCSF will be necessary to ensure that the program is consistent with how the CCSF envisions its role in providing health care to the indigent. At a minimum, the Director the Health will be an ex-officio member of the governing body. To ensure sufficient representation from the CCSF on

financial matters, the Controller will also be an ex-officio member of the governing body. The Committee recognizes that there may be compelling reasons to revisit the voting status of the CCSF representatives on this governing body. Given the level of funding and oversight of the public health safety net responsibility resting with the Director of Health, a voting seat on the governing body may be appropriate. However, if this is pursued, then systems must be established to ensure that the Director of Health adheres to the conflict of interests provisions outlined for the governing body.

In addition to the background and experience listed above, potential members for the governing body should be screened for such attributes as leadership, team-work, innovation and problem-solving. Individuals with these characteristics will strengthen the effectiveness of the governing body.

C. Governing Body Conflict Of Interest

Unless the governing body is subject to stringent conflict of interest provisions, members of the governing body may have vested interests and may inappropriately bring those interests to bear on decisions of the purchasing program. The governing body must have procedures set in place to eliminate potential conflicts. Accordingly, the following conflict of interest provisions will apply:

(a) No member of the governing body may be an employee of, a consultant to, or a member of the board of directors of any insurer, hospital services plan or health care services plan or an insurance broker or agent doing business with the purchasing program.

(b) No member of the governing body may be an employee of, a consultant to, or a member of the board of directors of any provider of health care services that (1) does business with the purchasing program or (2) that provides services to enrolled

members of the purchasing program, whether directly through the purchasing program or through another entity that has a contract with the purchasing program.

(c) No member of the governing body may enter into a contract with the purchasing program, nor be an employee of, a consultant to or a member of the board of directors of any entity that contracts with the purchasing program.

(d) The restrictions in (a), (b) and (c) do not apply to public officials serving ex officio on the governing body.

(e) No member of the governing body shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any decision in which he or she knows or has a reason to know he or she has a financial interest, as defined in California Government Code section 87103.

(f) An enrolled member of a health plan that participates in the purchasing program shall serve on the governing body as a representative of enrolled members and may vote on matters affecting enrolled members generally, without such participation and voting constituting a conflict of interest.

D. Governing Body Member Terms

The terms of the membership will be staggered. The first set of governing body members will have either a three (3) or five (5) year term. All subsequent terms will be for 5 year periods. No individual shall serve on the governing body for more than 10 years (either in individual or consecutive terms).

By resolution, a member of the governing body may be removed from office by the Board of Supervisors, either by initiation of the Board of Supervisor or upon the recommendation of the governing body for cause. If the Board of Supervisors wishes to

remove a governing body member from office without the recommendation of the governing body, then it must hold a hearing and adopt a resolution removing the governing body member with a two-thirds majority vote.

Members should not serve at the pleasure of the appointing authority. A member of the governing body may resign from office by submitting a written notice of resignation. Upon appointment to office, a voting governing body member must sign an agreement indicating that he/she will not engage in any financial activity or contracting with the purchasing program, or any of its contracted health plans, for a minimum of 12 months after leaving office.

E. Governing Body Appointment Process

The governing body appointment process consist of two components: (1) the initial appointment process and (2) subsequent appointments. The initial appointment process is as follows:

- of the seven voting members, four (4) would be nominated by the Mayor and three (3) would be nominated by the Board of Supervisors,
- the Board of Supervisors would ratify (i.e., appoint members by adopting a resolution) all seven nominees and appoint them to the governing body and
- the ex-officio members (the Director of Health and the Controller) will not be ratified by the Board of Supervisor.

After the initial appointments, all subsequent appointments for the governing body would be self-perpetuating. All members initially appointed by the Board of Supervisors and seeking a second term of office, and all subsequent members of the governing body shall be appointed in the following manner.

- the governing body will formally notify the Board of Supervisors of all individuals considered for appointment to the governing body,

- if the Board of Supervisors does not support the appointment, then within 60 days of receiving written notice to the Clerk of the Board of the proposed governing body appointment, the Board of Supervisors must hold a hearing on the proposed appointment and adopt a resolution in opposition to the appointment within 60 days and
- the Board of Supervisors is not required to take any formal action (either holding a hearing or adopting a resolution) if it supports the appointment.

F. Governing Body Committees

The governing body will establish standing and ad hoc committees to address specific issues related to the planning, implementation and administration of the purchasing program. Committee appointments and proceedings will be defined in the governing body's by-laws.

IX. UNDERSTANDING FINANCIAL RISK

The financial risks associated with implementing this purchasing program occur on numerous levels: (1) risk to the purchasing program, (2) risk to the health plans, (3) risk to the providers, (4) risk to the taxpayers and (5) risk to the CCSF. It is critical to understand the financial risks involved in starting up this insurance plan.

A. Risk to the Purchasing Program

The purchasing program will be at risk on two levels, first for the program's enrollment and second for the rate of business participation. The purchasing program must accurately estimate the number of subsidized persons who will enroll in the program. If the projection is underestimated relative to available funding, then the program could potentially run out of money in any given year. To ensure that enrollment does not exceed the budgeted level, the purchasing program should actively monitor the rate of subsidized enrollment. Prior to reaching its maximum available subsidy, the purchasing program will need to stagger or delay additional subsidized enrollment.

In order to effectively spread risk, a large and diverse (in terms of age, sex, health habits) pool of enrollees is needed. The purchasing program should have a substantial base of working individuals who are relatively in good health. If the purchasing program enrolls disproportionately individuals who have significant unmet clinical needs such as multiple chronic conditions, then actual per member per month cost will most likely exceed the budgeted amount. Enrolling younger, relatively healthy individuals who will not need to use high cost services will be critical to the financial survivability of the purchasing program. In order to ensure that this happens, the purchasing program must aggressively market its product and educate employers and the working uninsured about the benefits of health insurance. Premium contributions from private employers and their workers will be necessary to ensure that this program is not solely funded by the CCSF.

B. Financial Risk of Health Plans

Under managed care capitated systems health plans assume financial liability if expenses for providing care exceed the total capitated payment since services are not paid on a fee-for-service basis. In a capitated financial system, the health plan is "at-risk" for all health services rendered regardless of how costly the services are. It is not uncommon for health plans to share or distribute this risk to providers. As noted previously, a number of the uninsured have special health care needs and are likely to utilize more services than average or require more costly specialized services, especially in the first year of coverage. This "pent-up demand" has been seen in other purchasing programs but tends to stabilize as the program matures.

The Committee strongly recommends the establishment of risk-adjusted capitation rates for this program. Risk adjustment refers to arrangements that adjust the capitated payment to plans to reflect some change in the risk of caring for a population (generally those with certain illness or those at high risk for illness.[38] Risk adjustment gives health plans and their provider networks compensation needed to serve vulnerable populations -- special needs and chronically ill populations.

However, currently risk adjustment is used sporadically, and as a science, it is at a rudimentary level -- it is difficult and expensive.[39] While it is common to take into account age, sex, gender and utilization in developing capitation rates, it is less common to adjust rates for such factors as number of persons with disabilities in the health plan, diagnosis, socio-economic conditions or community health status.

Risk adjustment may also be done retrospectively. The purchasing program may establish a risk adjustment mechanism among health plans similar to one used by the Health Insurance Plan of California. Under this procedure, financial risk is shared

[38] Peter Boland, e d. Making Managed Healthcare Work. A Practical Guide to Strategies and Solutions. pp 350 - 354. 1993

[39] In Pursuit of Value. Innovative Sate Medicaid Purchasing Strategies. Alpha Center. March 1997

through providing retrospective adjustments to reimburse plans for losses incurred by members who utilize high cost services. A health plan whose utilization and health care costs are lower than the average of all plans and, therefore, did not use all their capitated funds, would be required to transfer funds to health plans with higher than average utilization.

Another method of containing risk is through stop loss arrangements. Stop-loss provisions protect health plans against extremely high cost health care cases. The actuarial analysis for this program provided estimates of per member per month costs with an annual stop loss provision of $30,000. Finally, establishing funding agreements with risk corridors can also pursued. Risk corridors limit the amount of revenue that health plans can earn, as well as the amount of loss they can sustain. This mechanism reduces the incentive to limit services inappropriately or to avoid enrolling high-cost individuals.

C. Financial Risk of Providers

Similar to health plans, providers will be at risk for the level of services used by their health plan members. They face the same financial liability issue as health plans. The most appropriate means of acknowledging the risk of providers is to adjust their capitation rate to accurately reflect anticipated health care utilization. Any prospective risk adjusted capitation rate should be reflected in the rate given to providers. While the Committee makes no recommendations on the risk sharing arrangements among health plans and providers, it recognizes that if providers are offered no risk protection, it may be difficult to attract providers to provide services in this purchasing program.[40]

[40] Tony Dreyfus, Richard Kronick, Carol Tobias and Medicaid Working Group. "Using Payment to Promote Better Medicaid Managed Care for People with AIDS." July 1997

X. PURCHASING PROGRAM'S RESPONSIBILITIES TO THE CCSF

As currently envisioned, the purchasing program will receive funding (either contractually or through an appropriations process) from the CCSF to provide health care coverage to the uninsured. As part of its receipt of these funds, the governing body of the purchasing program should be required to publicly report on the following: (1) its fiduciary condition, (2) how the program is achieving the City's public health policy objectives and (3) its general programs and operations. These reports will be critical to ensuring that the CCSF understands how the community benefits from insuring individuals through this purchasing program.

A. Fiduciary Responsibility

The CCSF's interest in the purchasing program is predicated on the assumptions that: (1) the program can more efficiently use indigent care dollars and (2) the program can reduce the City's burden of paying for health care for the working poor (by inducing more employers to offer coverage). The purchasing program should consistently be required to measure and justify its value in meeting these two objectives.

Annually, the purchasing program should provide independent audits and reports on its activity and financial condition. In addition to this retrospective information, the purchasing program should also provide business plans which provide an indication of how the program intends to meet its future goals. The purchasing program must be responsive to the CCSF in order to receive its appropriation and/or to ensure that its appropriation is not reduced.

During the appropriation process, it is recommended that the purchasing program provide multiple year business plans for the CCSF to review. These plans will in no way commit the CCSF to fund the purchasing program, but will enable the CCSF to project future funding needs. The risk to the CCSF is that the program will enroll all

indigent persons and no employers will participate. This would be a worst case scenario and, although unlikely, should be factored into any business plan. In order to ensure appropriate fiscal autonomy from the CCSF, the governing body must be willing to accept fiduciary responsibility of operating this purchasing program. The purchasing program should be allowed sufficient reserves to cover all of its planning assumptions.

B. General Annual Report

In addition to providing reports to the Mayor, the Board of Supervisors and the Health Commission, the purchasing program should also report to the public. This report would provide the overall framework and purpose of the purchasing program, what it has accomplished, and what it plans to do in the upcoming year. The purpose of this report is to show the public that this program is either saving money or is a more cost-effective way of delivering comprehensive services to the uninsured.

C. Public Health Policy Objectives

In order to justify the creation of a new separate public entity, the entity must further public health goals that either cannot or have not been met through the current government programs. The purchasing program must provide a larger perspective on its activities. Access to health insurance does not necessarily improve health status. Therefore, the purchasing program should provide information on the following:

- how it is accomplishing the larger public policy goal of expanding health care to the uninsured,
- collection of public health outcome measures,
- documentation on consumer satisfaction, and
- number of plans and providers that participate in the program.

The program should be able to document its success in terms of:

- enrolling the targeted uninsured population,
- increasing access to primary care service for the uninsured,

- reducing utilization of emergency and inpatient services by the uninsured population,
- reducing hospitalizations for preventable conditions (e.g., asthma) and
- reducing morbidity and mortality rates for the uninsured.

XI. PUBLIC SECTOR SAFETY NET ISSUES

Throughout its deliberations the Committee has had strong leadership and input from the San Francisco Department of Public Health (DPH). In addition, DPH staff have actively participated in sub-committees and DPH has provided data and information on utilization of health services by the indigent. This has been invaluable to the Committee's understanding of health care utilization trends of these populations and of the current financing system.

The Committee and DPH share a common mission and overriding goal to improve the quality of life for all San Franciscans. The DPH mission statement explicitly states a commitment to "ensure equal access to all." Similarly, the Committee has been asked to look at how to make health insurance universally available within San Francisco.

San Francisco's traditional safety net for health care, consisting of the Department of Public Health's Community Health Network (CHN) and the non-profit community-based consortium clinics, is one of the best in the nation. The CCSF's safety net system is a comprehensive, integrated system of care which has historically provided care for the City's ethnically and culturally diverse medically indigent and uninsured residents. CHN serves San Francisco through its multiple missions as medical provider, educator, researcher, employer, and community partner.

As noted previously, an estimated 130,000 residents are uninsured. It is estimated that the CHN serves approximately 71,000 or 54% of this population.[41] Table 10 shows that the CHN is a vital provider of health services to uninsured residents of San Francisco and the CHN safety net has been the major provider for the uninsured African-

[41] San Francisco Department of Public Health, Community Health Network Registration and Eligibility Data, 1996-97.

Table 10

Ethnicity	CHN Uninsured 100% = 71,129	
White	31%	22,238
African-American	21%	15,033
Latino	25%	17,952
Asian/Pacific Islander	17%	12.062
Others	6%	4,230

Age	CHN Uninsured 100% = 71,129		City Uninsured Estimates	
0-17	13%	9,254	10%	13,000
18-64	86%	61,505	86%	111,800
65+	2%	1,251	4%	5,200

Uninsured patients receive assistance in applying for benefits through Medi-Cal or Medicare. If they are determined ineligible for these programs, then their eligibility for the County Medical Assistance Program (CMAP) is determined. CMAP is a program for patients who are found to have no financial sponsorship and are indigent, or who have limited income and would otherwise be unable to pay for the full costs of their medical services. They are assessed for services on a sliding fee scale. Not all uninsured are eligible for CMAP (e.g., tourists and persons residing in other counties), however, no uninsured San Franciscan are turned away.

Within the CHN uninsured patient population, Table 11 on the next page shows that non-working adults are more likely to be homeless and have a higher use of services than CHN insured patients. This remains true when compared to general population projections for commercially insured individuals (4 visits per year, 200 acute days per 1,000 plan enrollees).

Table 11

Fiscal Year 1996-1997 Utilization	All CHN Insured	CHN Adult Working Uninsured	CHN Adult Non-Working Uninsured	CHN Adult Uninsured Work Status Not Collected COPC Patients	Estimate of Adult Uninsured
Patients	70,320	17,261	12,945	39,537	117,000
Est. Homeless (self-reported)	4%	3%	20%	13%	
Primary Care Patient	51%	21%	25%	63%	
Emergency Room Utilization	24%	57%	58%	32%	
Specialty Clinic	29%	51%	60%	17%	
Avg. number of visits per patient	9.2	8.1	10.1	8.4	
Average Acute Discharges/ Discharge Days	0.2 dschg 1.3 days	0.1 dschg 0.5 days	0.2 dschg 1.4 days	0.1 dschg 0.5 days	

As reported by the National Public Health and Hospital Institute, the non-working uninsured population is more costly to treat. As such, they are more likely remain with safety net providers such as the CHN:

"For many reasons, the indigents are a significantly more costly population to provide services to than the general population. They often are diagnosed with multiple conditions requiring extensive treatment, have complicated drug and alcohol dependencies, and mental illness. Adding to the costs is the fact that these individuals are more likely to seek care in the Emergency Department as opposed to a primary care physician."[42]

At least 17,000 working uninsured patients received care last year within the CHN (see Table 11) It's estimated that 40,000 of all CHN adult uninsured were employed.[43] The

[42] National Public Health and Hospital Institute "Survey of Managed Care Programs for the Indigent". 1996

[43] The 40,000 patients cared for in the community-based CHN clinics were not identified as "working" or "non-working." The estimate for CHN's working uninsured is derived by applying the same percentage of working and non-working as those whose status were known

working uninsured patient population of the CHN more closely reflects the utilization rate of the commercially insured individuals.

The Committee believes that it is essential for CCSF to maintain a safety net even with the development of a purchasing program. The safety net is a critical component in the CCSF's efforts to care for all residents. The Committee finds the following reasons for ensuring that a viable safety net continues:

- due to the voluntary nature of the purchasing program some people may continue to be uninsured,
- the safety net can provide supplemental services to those with special needs or those within the purchasing program who have exhausted their benefits,
- the safety net provides a set of unique services that are not provided in the private sector and
- patients will be able to access carved out services.

As can be seen, all of the reasons relate to ensuring access to health care which is a fundamental principle of the Committee's work.

The Committee believes that because of the voluntary nature of this purchasing program, there will continue to be some small employers who for financial or other reasons cannot or will not participate. In addition, some employees, self-employed residents, college students and part-time workers may be unable to or may choose not to enroll. Finally, in order to prevent a regional magnet effect, the Committee has recommended that the purchasing program consider a six-month waiting period before an indigent or low-income person would be eligible for a subsidy in this program. Accordingly, even if the program is successful, there would likely still be some people living in San Francisco who would remain uninsured. These individuals would still need a safety net system of care to access needed services.

Secondly, the safety net has historically provided care to residents with multiple health needs. For example, complex, acute and chronic mental health patients need a coordinated system of care that includes medical care, case management and psychiatric care. The proposed benefits package, while comprehensive, may not be adequate for individuals such as this. These individuals may require supplemental services beyond those provided such as additional mental health or chemical dependency services. Some members may need additional case management services. The safety net system will be able to provide this treatment.

Thirdly, the safety net often provides a unique set of services that cannot be found in the private health care market. One example of this is trauma care. San Francisco General Hospital (part of the CHN) is the only Level 1 trauma center in the City and County and it treats approximately 3,000 patients annually. Its official designation means that it is responsible for providing care to seriously injured patients in order to prevent death or disability. Most San Francisco hospitals are not adequately staffed to properly care for major trauma victims. The delivery of trauma care is not limited to the uninsured. All San Francisco residents, tourists and commuters benefit from this valuable service. Level 1 trauma capability will always be needed and the purchasing program must ensure that its enrollees have access to this service.

Fourth, the purchasing program has carved out services. Specifically, mental health services for seriously mentally ill adults and seriously emotionally disturbed children and physical health services for children eligible for California Children's Services. Safety net providers are equipped and trained to provide individuals with these needs with specialized services.

The Committee is extremely sensitive to the unique challenges, responsibilities and expertise of DPH's Community Health Network and all its affiliated partners. The Committee is also acutely aware of the fiscal challenges of these and other safety net

providers. They face the prospect of less federal and state revenues, more competition from private sector providers for patients/covered lives, increasing costs, and more demand for services, data reporting and infrastructure development. DPH continues to develop systems to provide uniquely designed behavioral health care including, mental health, drug treatment, and supportive services needed to keep people independent and in safe and stable housing.

The Community Health Network has shown great adaptability in the current health care reform movement. This is due in part to unwavering support by the Mayor and the Board of Supervisors to dramatically restructure services, achieve integration of services across a continuum of care, and obtain necessary information systems which track costs, utilization and provide comprehensive patient-specific clinical records.

The Committee views the safety net system as invaluable to the delivery of services to the uninsured, the poor and those with commercial insurance. The Committee recommends a number of options that should be studied by the purchasing program for ensuring safety net participation in the program. These include:

- creating financial incentives to encourage health plans to include safety net providers in their networks,
- having the purchasing program work with safety net providers to pre-determine "high utilizers" and risk adjust rates prospectively for this population,
- studying the impact of eliminating co-payments for enrollees who choose safety net providers on the program costs and on patient choice
- having DPH and the purchasing program jointly agree on key public health measures and standards that should be achieved and monitored. The Director of Health will be a member of the governing body in part to assure that city-wide public health goals are being actively addressed though the purchasing program.

The Committee is optimistic about the ability of the purchasing program to attract private employer premiums. It sees DPH and other safety net providers as having a strong competitive advantage to attract uninsured persons given their expertise and cultural (and linguistic) competence. We hope that the possibility of providing comprehensive health care to 130,000 uninsured people is seen by safety net providers as an opportunity to further their mission to create more equitable access to a minimum benefit standard for low-income people in San Francisco. For example, if the purchasing program successful provides insurance to all those with incomes less than 200% of the federal poverty level, then there would be a 60% reduction in the number of San Francisco's uninsured (see Section III).

However, the Committee recognizes that in order for safety net providers (i.e., the Community Health Network which includes San Francisco General Hospital, community-based primary care clinics and its affiliated providers) to become providers of first choice, rather than providers of last resort, a number of measures must be taken by the Mayor, Board of Supervisors and Health Commission. These include the need to *market* the CCSF's health care system and its quality programs to CCSF employees, other commercially covered populations and to the newly insured under this program. The CHN's capital and infrastructure needs must be regularly assessed and financed in order to attract patients who have a choice of where to obtain care. Likewise, the CCSF should work to assure a single high quality class of care for all patients regardless of their income status.

The purchasing program in conjunction with the Controller, the Director of Health, and the Health Commission, would monitor patient volume, acuity, cost per unit of service, and effectiveness of risk-adjusted rates to address potential adverse patient case-mix within the CHN and its affiliated partners. Any unintended consequences of the purchasing program must be promptly identified and mitigated where appropriate. The Committee recognizes the immeasurable public good afforded to CCSF due to the

premier research and teaching programs offered by the University of California at San Francisco School of Medicine ("UCSF") at San Francisco General Hospital. The Committee believes, in fact, that the CCSF and UCSF affiliation must continue to be valued and supported, notwithstanding the implementation of these recommendations. However, this relationships and the clinical care that is provided as a result of any affiliation should not be based on relying on patient volume solely from the indigent and uninsured population, as it is today. These providers must continue to receive the necessary CCSF support needed to actively draw in patients from all economic classes and payer sources -- making their strengths and assets in the delivery of health care available to all comers.

XII. COMMUNITY INPUT

A series of community forums and presentations were held from January 1998 to April 1998 to discuss preliminary findings of the Mayor's Blue Ribbon Committee on Universal Health Care. The forums and presentations were an opportunity to provide information on the Committee's progress to consumers, employers, community based organizations, CCSF agencies, health care providers and other interested parties.

The forums took place in several locations around the City. Five forums were open to all interested parties including, residents, community-based organizations, providers, advocacy groups, health plans and associations. Additional forums were given to specific audiences -- business owners, San Francisco Health Commission, providers and others. Extensive outreach was done in preparation for the forums. In addition to distributing an informational flyer, the Department of Public Health had the forum notice placed on the CCSF's website, worked with Channel 54 to have a television announcement made, placed a notice in the Bay Guardian and regularly mentioned the forums at other community meetings.

During and after the formal presentation, attendees raised several questions. Overall, the attendees expressed enthusiasm about the CCSF developing a program to provide health care coverage to the uninsured. Comments and questions raised by the San Francisco community included:

- eligibility criteria for the program,
- how funding for the program would be secured,
- which health plans would be providing services,
- when the program would be operational,
- what impact this program would have on existing safety net providers,
- inclusion and exclusion of some health benefits and
- whether the program could be mandated.

Committee members received a written of the community's concerns and feedback. Where possible, concerns and questions raised by the community have been incorporated into this report. A list of the community comments and questions are attached in Appendix D.

XIII. IMPLEMENTATION ISSUES

This report provides the framework and proposed model for expanding health insurance to the uninsured. It does not provide specificity on necessary implementation. An operational plan will be needed to fully describe what steps should be taken to implement the program. The following is intended to identify the primary features necessary to implement the program.

Ultimately, implementation of the program will require the following actions to be taken:

Actions Needed by the CCSF:

- Establishment of an implementation team by the Mayor of San Francisco -- These individuals will be responsible for all aspects of the implementation. Team members should have experience in understanding the needs of the uninsured and the provision of care necessary for this population, implementing health insurance programs, and in developing and maintaining managed care systems.
- Creation and appointment of the governing body by the Board of Supervisors -- As mentioned in Section VIII, a governing body is needed to ensure overall oversight of the purchasing program. Nominations for the governing body will be from the Mayor and the Board of Supervisors

Actions Needed by the Implementation Team:

- Seek appropriate legislation to establish the purchasing program's legal status -- State legislation currently governs the creation of purchasing alliances. San Francisco will need to obtain authorizing State legislation to create a separate non-profit public benefits corporation. In addition, local legislation adopted by the Mayor and Board of Supervisors will also be needed

- Conduct further analyze on assumptions with respect to eligible population, utilization and financial model -- This report provides cost estimates based on global data on the uninsured. Additional analysis such as primary surveys or other sources of data will be needed for further actuarial analysis. The Committee has not tested the effect of a subsidy on the purchasing decisions of the working poor. Additional analysis is also needed to test assumptions related to employer participation.
- Conduct additional focus groups with the uninsured, business community and insurance brokers -- The purchasing program will only succeed to the extend that it offers a service which is needed and affordable. Additional focus groups will necessary to determine the interest of each of these groups in participating in the program.
- Design appropriate administrative system -- A day-to-day administrative structure will be needed. The administrative structure can be built or the governing body can contract with a third party administrator to manage operations. Basic administrative activities will include eligibility determination, application processing and enrollment.
- Design service delivery system -- A comprehensive service delivery system is needed to ensure that the uninsured are served in an appropriate manner.
- Procure a provider network -- Providers will be needed to deliver services to the enrolled members. In keeping with the goals of the Committee, comprehensive and coordinated service networks should be developed -- those offering a full array of primary, secondary and tertiary services in a variety of care settings.

Because the purchasing program will be voluntary, education and outreach to the business community and to residents will be vital to the program's success. Promoting the benefits of health insurance, the comprehensiveness of the benefits package, and the simplified administrative and enrollment structure of this program will be essential. The implementation strategy must focus on selling the benefits of health care coverage.

Employers and the uninsured will not be interested in this program unless they value health insurance.

Implementing a purchasing program is complex and the Committee strongly recommends phasing the program in. A phased-in approach would allow the County to gain practical experience in starting up the program before attempting to cover all 130,000 uninsured residents at once. While the Committee makes this recommendation, it also recognizes that the larger the number of individuals participating in the program, the better able the purchasing program is to spread risk.

A phase-in is critical in determining whether the benefits package, financing mechanisms, management information system and other programmatic components are suitable. The Committee entertained phase-in proposals, but felt that a formal comprehensive request for proposals should be made by the purchasing program's governing body prior to implementation. The phase-in could be based on stratifying the population by employment status, zip code, income level, or special population (e.g., General Assistance recipients, parents of children enrolled in the Healthy Families program, etc.). Principle features in designing a phase-in include determining:

- the number enrollees to participate,
- duration of the first phase-in,
- total amount of funding required,
- crowd-out policy (e.g., income limits, periods of being uninsured, additional residency requirement, etc.),
- target population that will be enrolled and
- health plan and provider network participation.

A consumer satisfaction component should also be designed into the phase-in. This will provide an opportunity for consumers to comment on the quality of care, level and types of services, enrollment and disenrollment into the program, premium and co-payment structure, and choice of health plans and/or providers. A fundamental

premise in designing this purchasing program is that it is more effective and cost-efficient manner of providing care to the uninsured than the current method. Consumer satisfaction is one way of measuring whether or not this occurs.

Ascertaining consumer satisfaction is part of a larger evaluation that should be done for the proposed purchasing program. The evaluation will help determine how successful the program is in achieving its overall goal to reduce the number of uninsured. The Committee recognizes that the impacts of implementing the proposed purchasing program are largely unknown and therefore urge any implementation team to closely monitor its development. Below are questions that the Committee believes should be considered during the first phase-in before the program is expanded. Answering these questions can assist the governing body in determining the future direction of program.

Administration

- Do the various means testing components, etc. make the program too costly or complex to administer?
- Are administrative cost reasonable?

Crowd-Out Issues

- Are the majority of firms that enroll in the program firms that previously provided health care coverage, but enroll in this program because it is less costly?
- Are the enrollment provisions and restrictions sufficient to deter crowd-out?
- Overall , have employers maintained or increased their commitment (financial) in health?

Employer Participation

- Do small businesses participate in the purchasing program? At what level of benefits and premium cost will employers participate?

- What employment sectors are more or less likely to participate?
- Does the fact that an individual can sign-up for the program without their employer discourage employers from participating?
- Does the purchasing program offer an incentive for businesses to locate in San Francisco or employ San Franciso residents?

Financing Structure

- Is the co-payment and premium structure a barrier to enrollment?
- Overall, is the CCSF finding itself spending money on a population(s) that it had previously not intended to support with indigent health care funds?
- How much is the CCSF spending to support this new program and the safety net system?

General Design

- Is this purchasing program a more cost-effective manner to provide health care (i.e., utilization, cost, etc.)?

Health Plan Participation

- Is the per member per month capitation rate sufficient to induce health plans to participate?

Membership

- Do individuals sign-up for the program even if their employer chooses not to participate?

Providers

- Does this purchasing program result in persons changing providers once they have access to health insurance?

- What impact does the program have on the patient volume of safety net providers?

Public Health

- Is there any impact on achieving public health goals or maintaining public health standards?

Scope of Benefits

- Does the benefits package adequately meet needs or does it need to be revised?

CONCLUSION

Reducing the number of uninsured are public health and quality of life issues. It is incumbent upon all of us to view health care as a public good -- something that all residents are entitled to regardless of their employment participation, financial resources or legal status. Universal access to health insurance is achievable. The Committee proposes the adoption of a purchasing alliance for public and private employers, and the restructuring of indigent care funds to subsidize premiums for very low-income persons.

In particular, health care coverage to the uninsured, low-income, working poor can be expanded by restructuring CCSF indigent care funds within a purchasing program that pools funding from government agencies, private businesses and individuals. Restructuring the public subsidy fosters consumer choice and allows the purchasing program to leverage greater participation from private employer.

One of the primary reasons for the high uninsured rate is the cost of health insurance -- employers and employees find health care unaffordable. Small employers (those with fewer than 50 employees) are less likely to offer coverage; employees earning less than $10 per hour are less likely to accept coverage if it is offered to them. If the CCSF subsidizes a portion of the premium for low-income workers and the indigent, then more employers and individuals will be able to purchase health care coverage. The Committee has structured the CCSF subsidy so that it is targeted to the most needy, based on means testing a family's income.

The proposed scope of benefits available under this purchasing program will be comprehensive. It is based on the benefits package offered by an existing state-wide purchasing program (i.e., Health Insurance Plan of California). One of the guiding principles for the Committee was to offer a scope of benefits which was "comparable to

that provided in the private market." It is vitally important that the benefits offered through this purchasing program not be seen as substandard or piecemeal. Based on the cost estimates and analysis, the proposed per member per month premium for this program is within the range of commercial rates.

The voluntary nature of this program means that the CCSF will continue to need a public safety net system for the uninsured who do not enroll in this program and/or for those who need services not included in the benefits package such as case management or residential drug treatment. The Committee believes that safety net providers, such as the Community Health Network, are a critical component of any structure to deliver care to the uninsured.

The Committee believes that implementation of this purchasing program should be phased-in to ensure that the assumptions with respect to enrollment, cost, provider participation, crowd-out and administrative cost can be accurately assessed for financial feasibility and for improved health status of the enrolled populations.

Finally, the Committee wants to acknowledge Mayor Willie L. Brown, Jr. for his longstanding leadership in the area of equal access for health care and for this vision to create in San Francisco that which should and could be done throughout the country.

REFERENCES

1998 Health and Human Services Poverty Guidelines, February 1998

AIDS Policy Center for Children, Youth and Families, Setting Capitation Rates for HIV/AIDS Care: A Primer for Ryan White CARE Act Title IV Projects, February 1998

Stuart Altman, Uwe Reinhart and Alexandra Shields (eds.), The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?, 1998

David Ansell, M.D., MPH, Gordon Schiff, M.D., Stuart Dick, MPH, Carrie Cwiak, M.D. and Kadijah Wright, M.D., "Voting with Their Feet: Public Hospitals, Health Reform and Patient Choices," *American Journal of Public Health*, March 1998, Volume 99, No. 3

Raymond Baxter and Robert Mechanic, "The Status of Local Health Care Safety Nets," *Health Affairs*, Volume 16, Number 4, July/August 1997

Andrew Bindman, M.D., Associate Professor of Medicine and Epidemiology, University of California at San Francisco, San Francisco County Estimates of Health Insurance, December 1997

Peter Boland, e.d, Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions, 1993

California Department of Finance, San Francisco Profile, 1997

California HealthCare Foundation, California's Uninsured: Understanding a Complex Issue, Februray 1998

Deborah J. Chollet and Adele M. Kirk, Understanding Individual Health Insurance Markets, Alpha Center, March 1998

Deborah Chollet, Michael Birnbaum and Michael Sherman, Deterring Crowd-out in Public Insurance Programs: State Policies and Experience, Alpha Center, October 1997

Congressional Budget Office, Behavioral Assumptions for Estimating the Effects of Health Care Proposals, 1993

Philip Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers For Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, Volume 16, Number 6, November/December 1997

Tony Dreyfus, Richard Kronick, Carol Tobias and Medicaid Working Group, "Using Payment to Promote Better Medicaid Managed Care for People with AIDS," July 1997

Jon R. Gabel, Paul B. Ginsburg and Kelly A. Hunt, "Small Employers and Their Health Benefites, 1988 - 1996: An Awkward Adolescence," *Health Affairs*, Volume 16, Number 5, September/October 1997

Deborah W. Garnick, Katherine Swartz and Kathleen Carley Skwara, "Insurance Agents: Ignord Players in Health Insurance Reform," *Health Affairs*, Volume 17, Number 2, March/April 1998

General Accounting Office, Health Insurance: Management Strategies Used by Large Employers to Control Costs, May 1997

Caren Ginsberg, Ph.D., Anne Gauthier (ed.) and Karen Brodsky (ed.), In Pursuit of Value: Innovative Sate/Medicaid Purchasing Strategies, Alpha Center and the Center for Health Care Strategies, March 1997

Health Insurance Policy Program, The State of Health Insurance in California, 1997, University of California at Berkeley and University of California at Los Angeles, January 1998.

Kelly Hunt, Sara J. Singer, Jon Gabel, Derek Liston, and Alain C. Enthoven, "Paying More Twice: When employers Subsidize Higher-Cost Health Plans," *Health Affairs*, Volume 16, Number 6, November/December 1997

Henry J. Kaiser Foundation, "Uninsured in America -- Key Facts About Gaps in Health Insurance Coverage Today," 1998

Henry J. Kaiser Foundation, "Access to Care: Is Health Insurance Enough?," March 1995

Myra Lappin, M.D., "San Francisco State Student Health Needs Survey," Public Research Institute, May 1996

Katharine R. Levit, Helen C. Lazenby, Bradley R. Braden, and the National Health Accounts Team, "National Health Spending in 1996," *Health Affairs*, Volume 17, Number 1, January/February 1998

Lewin-VHI, Inc., A Report on the State of Health Care in California, June 1995

Debra J. Lipson, Daniel M. Campion and Michael Birnbaum, Approaches for Providing/Financing Health Care for the Uninsured: An Assessment of State Options and Experiences, Alpha Center, August 1997

MMWR, "Demographic Characteristics of Persons Without a Regular Source of Medical Care -- Selected States, 1995," Volume 47, Number 14

National Public Health and Hospital Institute "Survey of Managed Care Programs for the Indigent," 1996

San Francisco City College, Health Services Department

San Francisco Department of Human Resources, Health Service System

San Francisco Department of Public Health, Community Health Network, Registration and Eligibility Data, 1996-97

San Francisco Department of Public Health, "Medically Indigent Care Reporting System (MICRS) Data Summary Report No. 5," November 1997.

San Francisco Tax Collector, Business Tax Information System

Cathy Schoen, Barbara Lyons, Diane Rowland, Karen Davis and Elaine Puleo, "Insurance Matters for Low-Income Adults: Results from a Five-State Survey," *Health Affairs*, Volume 16, Number 5, September/October 1997

Steven A. Schroeder, M.D., "The Medically Uninsured -- Will They Always Be With Us?," *New England Journal of Medicine*, April 25, 1996.

Pamela Farley Short, ph.D., Beth A.Hahn, Ph.D., Karen Beauregard, M.H.A, P. Holly Harvey, M.P.P. and Melissa Lemberg Wilets, B.A., "The Effects of Universal Health Coverage on Health Expenditures for the Uninsured," *Medical Care*, Volume 35, Number 2, 1997

State of Hawaii, Auditor, Audit of the QUEST Demonstration Project, December 1996.

United States General Accounting Office, Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures, July 1997

United States General Accounting Office, Employment-Based Health Insurance: Costs Increases and Family Coverage Decreases, February 1997

United States General Accounting Office, Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs, November 1996

University of California at Los Angeles and KPMG Peat Marwick, 1997 Employer Health Benefits Survey, December 1997

Steve Wallace, PhD, Tanya Burton, MSPH, Hongjian Yu, PhD and E. Richard Brown, PhD, "Uninsured Low-Income Children Eligible for California's Healthy Families Program," December 1997

J.S. Weissman, MD, C. Gastonis, MD and A.M. Epstein, MD, "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland," *Journal of the American Medical Association*, Volume 268, 1992

GLOSSARY OF TERMS

Access — Potential and actual entry of a population into the health care system and by features such as private or public insurance coverage. The probability of entry is also dependent upon the wants, resources and needs that patients may bring. Actual entry into the system is described by utilization rates and subjective evaluations of care. Ability to obtain wanted or needed services may also be influenced by the distance one has to travel, waiting times, total income and whether one has a regular source of care.

Acute Care — Medical treatment rendered to individuals whose illnesses or health problems are of a short-term or episodic nature.

Adverse Selection — A tendency for utilization of health services in a population group to be higher than average. Adverse selection occurs when persons with poorer than average life expectancy or health status apply for or continue insurance coverage to a greater extent than do persons with average or better health expectations.

Affordability — This is related to the cost of health services. It refers to the financial ability of individuals and employers to pay for health insurance. This definition does not address the willingness to pay for coverage.

Ambulatory Care — All types of health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. The term usually implies that the persons must travel to a location to receive services which do not require an overnight stay.

Appropriateness — Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment.

Avoidable Hospital Condition — Medical diagnosis for which hospitalization could have been avoided if ambulatory care had been provided in a timely and efficient manner.

CalWORKS	California Work Opportunities and Responsibility to Kids Program; California's version of the federal Temporary Assistance to Needy Families (TANF) program. TANF is a new federal means tested program to assist people who need financial support to care for their minor children. It is not an entitlement.
Capitation	A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations.
Carve-Out	An arrangement whereby an employer eliminates coverage for a specific category of services (e.g., vision care, mental health/psychological services and prescription drugs) and contracts with a separate set of providers for those services according to a predetermined fee schedule or capitation arrangement. Carve-out may also refer to a method of coordinating dual coverage for an individual.
Case Management	The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services.
Case Mix	A measure of the mix of cases being treated by a particular health care providers that is intended to reflect the patients' different needs for resources.
Charity Care	Generally refers to physician and hospital services provided to persons who are unable to pay for the cost of services, especially those who are low-income, uninsured and underinsured.
Chronic Care	Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature.
Clinic	A facility, or part of one, devoted to diagnosis and treatment of outpatients.
Community-based Care	The blend of health and social services provided to an individual or family in their place of residence for the purpose of promoting, maintaining or restoring health or minimizing the effects of illness and disability.

Community Oriented Primary Care	A approach to providing primary care services that systematically identifies and addressed health problems in a defined population. Interventions may include both medical and non-medical interventions to meet the health care needs of the population.
Consumer	One who may receive or is receiving health services.
Co-Payment	That portion of a claim or medical expense which a member (or covered insured) must pay out of his or her own pocket. Usually a fixed amount.
Cost-Shifting	The condition that occurs when health care providers are not reimbursed or not fully reimbursed for providing health care so charges to those who pay must be increased. Typically results from providing health care to the medically indigent or the Medicare patients.
County Medical Assistance Program (CMAP)	CMAP is San Francisco's program for patients who are found to have no financial sponsorship and are indigent, or who have limited income and would otherwise be unable to pay for the cull costs of their medical services. The are assessed for services on a sliding fee scale.
Covered Life/Enrolled Member	Term used by managed care organizations to describe individuals enrolled in an organization. Each member of a family enrolled in a managed care organization is considered a separate covered life.
Crowd-Out	The possibility that some people will substitute public insurance for private insurance, or that employers will fail to offer insurance to reduce their contributions to coverage because a public insurance plan is available.
Deductible	That portion of a subscriber's (or member's) health care expenses that must be paid out-of-pocket before any insurance coverage applies.
Disease	A failure of the adaptive mechanisms of an organism to counteract adequately, normally or appropriately to stimuli and stresses to which it is subjected, resulting in a disturbance in the function or structure of some part of the organism.

Efficiency

"Productive" efficiency describes the performance of a service or delivery of medical care of a given quality with the least expenditure of resources. "Allocative" efficiency concerns not only whether care is provided as cheaply as possible given its costs and quality, but also whether the costs expended for the additional care are worth the benefits to be gained.

Employee Retirement Income Security Act (ERISA)

A 1994 federal act that established new standards and reporting/disclosure requirements for employer-funded pension and health benefits programs. To date, self-funded health benefit plans operating under ERISA have been held to be exempt from state insurance laws.

Employer-Based Health Coverage

Health insurance coverage offered by employers on behalf of their employees. The cost of this insurance is either fully or partially covered by the employer. The coverage is sometimes extended to the employee's dependents; however, this is usually done at increased cost to the employee.

Fee-For-Service

Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided or if more expensive services are substituted for less expensive ones.

Health

The state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health has many dimensions (anatomical, physiological and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms of morbidity and mortality.

Health Care Financing Administration

The federal government agency within the Department of Health and Human Services which directs the Medicare and Medicaid programs and conducts research to support those programs.

Health Insurance

Financial protection against the medical care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis.

Health Insurance Purchasing Cooperatives

Public or private organizations which secure health insurance coverage for the workers of all member employers and make that coverage more affordable by spreading risk over a larger population. The creation of these large risk pools give small employers greater bargaining clout with health insurers, plans and providers, approximating that traditionally enjoyed by large businesses. Furthermore, pooling of purchasing power reduced the administrative costs of buying, selling an managing insurance policies. Private cooperatives are voluntary associations of employers in a metropolitan area who band together to purchase insurance for their employees. Public cooperatives were established by state governments to purchase for state employees, county and municipal workers and other public entities.

Health Maintenance Organization

An entity with four essential attributes: (1) an organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of, (2) an agreed upon set of basic and supplemental health maintenance and treatment of services to, (3) a voluntarily enrolled group of persons and (4) for which services the entity is reimbursed through a predetermined fixed, periodic pre-payment made by, or on behalf of, each person or family unit enrolled.

Health Promotion

Any combination of health education and related organizational, political and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health.

Health Status

The state of health of a specified individual, group or population. It may be measured by obtaining proxies such as people's subjective assessments of their health, by one or more indicators of mortality and morbidity in the population or by using the incidence or prevalence of major diseases. Health status is the outcome measure for the effectiveness of a specific population's medical care system.

Hospital

An institution whose primary function is to provide inpatient diagnosis and therapeutic services for a variety of medical conditions, both surgical and non-surgical. In addition, most hospitals provide some outpatient services, particularly emergency care.

Indemnity	Health insurance benefits provided in the form of cash payments rather than services. An indemnity insurance contract usually defines the maximum amounts which will be paid for the covered services.
Indigent Care	Health services provided the poor or those unable to pay. Since may indigent patients are not eligible for federal or state programs, the costs which are covered by Medicaid are generally recorded separately from indigent care costs.
Indigent Care Funding	Indigent care funding refers to local and state dollars allocated to provide health care services to persons who are indigent or who are uninsured. For the purposes of this analysis, this includes State Realignment, Proposition 99 Tobacco Tax Revenues and CCSF General Fund.
Individual Health Insurance Market	Health care coverage market that enables persons to purchase health insurance if they are unable to access coverage through an employer or are ineligible for publicly-funded health care.
Inpatient	A person who has been admitted at least overnight to a hospital or other health facility for the purposes of receiving diagnostic treatment or other health services.
Medicaid (known as Medi-Cal in California)	A federally-aided, state-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical services. The program is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria.
Medically Indigent	People who cannot afford needed health care because of insufficient income and/or lack of adequate health insurance.
Medicare	A federal health insurance program for people aged 65 and over, for persons eligible for social security disability payments and for certain workers and their dependents with disabilities. It consists of two separate but coordinated programs hospital insurance (Part A) and supplemental medical insurance (Part B)

Need	In health services, need has a normative connotation (i.e., the amount of a good or service which should be consumed). Because of the technical nature of medical care this value judgment is generally made by the health professional, rather than the consumer of the services. In health planning, need is the appropriate amount of health facilities and services required for a given area.
Outpatient	A patient who receives ambulatory care at a hospital or other facilities without being admitted into the facility. Usually, it does not mean people receiving services from a physician's office or other program which also does not provide inpatient care.
PMPM	Per member, per month. Specifically applies to a revenue or cost for each enrolled member each month.
Primary Care	Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral or social.
Primary Care Provider	The practitioner in managed care organizations who is an individual's regular provider and also determines whether the presenting patient needs to see a specialist or requires other non-routine services.
Primary Prevention	The prevention of an illness or disease before any symptoms manifest themselves.
Provider	Hospital or licensed health care professional, or group of hospitals or health care professionals that provide health care services to patients. May also refer to medical supply firms and vendors of durable medical equipment.
Public Good	A good or service whose benefits may be provided to a group at no more costs than that required to provide it for one person. The benefits of the good are indivisible and individuals cannot be excluded.

Public Health	The science dealing with the protection and improvement of community health by organized community effort. Public health activities are generally those which are less amenable t being undertaken by individuals or which are less effective when undertaken on an individual basis and do not typically include direct personal health services.
Purchasing Alliance/Program	Mechanism by which employers pool funds together to buy health care services for their employees. Allows employers to leverage their funding and obtain a reduction in the health care premium due to volume (i.e., increased number of employees).
Quality of Care	Can be defined as a measure o the degree to which delivered health services meet established professional standards and judgments of value to the consumer. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art. Quality is frequently described as having three dimensions: (1) quality of input resources, (2) quality of the process of services delivery and (3) quality of outcome of service use.
Risk or Risk Factor	Risk is used to quantify the likelihood that something will occur. A risk factor is something which either increases or decreases an individual's risk of developing a disease. However, it does not mean that, if exposed, an individual will definitely contract a particular disease.
Risk Adjustment	A process by which premium dollars are shifted from a plan with relatively healthy enrollees to another with sicker members. It is intended to minimize any financial incentives health plans may have to select healthier than average enrollees. In this process, health plans which attract higher risk providers and members would be compensated for any differences in the proportion of their members that require high levels of care compared to other plans.
Risk Selection	Occurrence when a disproportionate share of high or low users of care join a health plan.

Safety Net	Term designates those providers and health care facilities which have historically provided health care services to low-income, uninsured and indigent persons. Generally these provider are public or community-based, non-profit providers. Safety net providers have limited funding to provide services to these populations.
San Francisco Health Service System	The Health Service System is a division of the Department of Human Resources. It provides active and retired employees of the City and County of San Francisco, Unified School District and Community College District and their eligible family members the highest quality and most comprehensive employee benefit programs possible at the most reasonable cost.
Scope of Benefits	Health care services covered by an insurance plan.
Self-Funding of Health Benefits	An employer or group of employers sets aside funds to cover the costs of health benefits for their employees. Benefits may be administered by the employer(s) or handled through an administrative service only agreement with an insurance carrier or third-party administrator.
Small Employer	Defined in California law as businesses with at least two (2) but no more than fifty (50) employees. This definition does not include those individuals who are self-employed and employ no workers.
Stop Loss	Purchase of insurance that covers expenditures above a certain aggregate claim level and/or covers catastrophic illness or injury when individual claims reach a certain dollar threshold.
Uncompensated Care	Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity care. It includes bad debts from persons who are not classified as charity cased but who are unable or unwilling to pay their bills.
Underinsured	People with public or private insurance policies that do not cover all necessary medical service, resulting in out-of-pocket expenses that exceed their ability to pay.

Underwriting	Underwriting has two different meanings. In one definition, it refers to bearing the risk for something (i.e., a policy is underwritten by an insurance company). In another definition, it refers to the analysis of a group that is done to determine rates, or to determine if the group should be offered coverage at all.
Uninsured	People who lack public or private health insurance.
Utilization	Use; commonly examined in terms of patterns or rates of use of a single service or type of service (e.g., hospital care, physician visits, prescription drugs). Use is also expressed in rates per unit of population at risk for a given period.
Wellness	A dynamic state of physical, mental and social well-being. A way of life which equips the individual to realize the full potential of his or her capabilities and to overcome and compensate for weaknesses. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system) and lifestyle.

This glossary was compiled using the following sources for definitions:

- *Glossary of Terms as Commonly Used in Health Care* by Alpha Center, 1995
- *Managed Care Primer -- Glossary of Terms, Jargon and Common Acronyms* by KPMG Peat Marwick

APPENDICES

THE 1998 HHS POVERTY GUIDELINES

One Version of the (U.S.) Federal Poverty Measure

There are two slightly different versions of the federal poverty measure:

- the poverty thresholds, and
- the poverty guidelines.

The poverty thresholds are the original version of the federal poverty measure. They are updated each year by the Census Bureau (although they were originally developed by Mollie Orshansky of the Social Security Administration). The thresholds are used mainly for statistical purposes – for instance, preparing estimates of the number of Americans in poverty each year.

The poverty guidelines are the other version of the federal poverty measure. They are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes – for instance, determining financial eligibility for certain federal programs. (The full text of the *Federal Register* notice with the 1998 poverty guidelines is available here.)

1998 HHS Poverty Guidelines

Size of Family Unit	48 Continuous States and D.C.	Alaska	Hawaii
1	$8,050	$10,070	$9,260
2	10,850	13,570	12,480
3	13,650	17,070	15,700
4	16,450	20,570	18,920
5	19,250	24,070	22,140
6	22,050	27,570	25,360
7	24,850	31,070	28,580
8	27,650	34,570	31,800
For each additional person, add	2,800	3,500	3,220

SOURCE: *Federal Register*, Vol. 63, No. 36, February 24, 1998, pp. 9235-9238

Senate Bill No. 1559

CHAPTER 916

An act to add Chapter 9 (commencing with Section 10800) to Par 2 of Division 2 of the Insurance Code, relating to health insurance

[Approved by Governor September 25, 1996. Filed with Secretary of State September 26, 1996.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1559, Peace. Health insurance.

Existing law provides for the provision of health insurance coverage and similar health benefit coverage through carriers such as disability insurers, nonprofit hospital service plans, and health car service plans, and provides for the regulation of insurers by the Insurance Commissioner, and for the regulation of health care service plans by the Department of Corporations.

Existing law provides for the marketing of health insurance in various ways, including by insurance agents and brokers. Existing law specifically regulates the health coverage provided by carriers to small employers, and requires the filing of various information with regulatory authorities, and the offering of plan designs to all small employers.

This bill would authorize the formation of purchasing alliances, to be formed by individuals, partnerships, corporations, or trusts for the purpose of providing health benefits to employers, small employers, and their employees. The bill would authorize the purchasing alliances to offer various forms of coverage.

The bill would require purchasing alliances to meet certain criteria and to be certified by the Insurance Commissioner. The bill would provide that participating carriers that provide coverage through purchasing alliances would be subject to all laws that regulate health care coverage or medical benefits provided to employers, as specified.

The bill would provide that the violation of specified orders of the Insurance Commissioner would be a misdemeanor and thus the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The bill would require specified reports by the Bureau of State Audits.

The people of the State of California do enact as follows:

SECTION 1. Chapter 9 (commencing with Section 10800) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 9. THE PRIVATE HEALTH CARE VOLUNTARY PURCHASING ALLIANCE ACT

Article 1. General

10800. This chapter shall be known as the Private Health Care Voluntary Purchasing Alliance Act.

10801. The purpose of this chapter is to improve the competition in the pricing and delivering of health care coverage for employers and small employers. It does so by allowing for the establishment of private competing purchasing alliances through which eligible employers or small employers can purchase health coverage. Another goal is to avoid jurisdictional confusion by clarifying the respective roles and jurisdiction of existing regulatory agencies and a purchasing alliance. This chapter provides a mechanism for employers or small employers to join together solely for the purpose of procuring health coverage and operates as an exception to existing false group or fictitious group laws.

10802. This chapter is also intended to provide a meaningful choice of high quality, fairly priced health care providers, and health care coverage for participating employers and employees of a purchasing alliance through a system that is fair, efficient, and accountable to its members and includes procedural and substantive protections.

10803. It is envisioned that a purchasing alliance will contract with qualified group carriers to provide a meaningful choice of carriers providing health benefit plans or ancillary benefit plans to purchasing alliance participants.

Article 2. Definitions

10810. As used in this chapter:

(a) "Ancillary benefit plan" means a policy or contract written or administered by a participating carrier that covers dental or vision benefits for the covered eligible employees of an employer or small employer and their dependents.

(b) "Appropriate Regulatory Authority" means the Department of Insurance except for health care service plans, in which case it means the Department of Corporations.

(c) "Benefit plan design" means a specific health coverage product issued by a carrier to employers or small employers, to trustees of associations, or to individuals if the coverage is offered

through employment or sponsored by an employer or small employer. It includes the services covered and the levels of copayment and deductibles.

(d) "Board" means the governing body of the purchasing alliance. This term shall include the board of directors of a nonprofit corporation or trust, a for-profit corporation, the general partners of a partnership, or a sole proprietor.

(e) "Carrier" means any licensed disability insurance company or licensed health care service plan or any other entity that writes, issues, or administers any health benefit plan or ancillary benefit plan to employers or small employers in this state.

(f) "Commissioner" means the Insurance Commissioner, who shall have regulatory jurisdiction over purchasing alliances.

(g) "Dependent" has the same meaning as in the subdivision (a) of Section 1357 of the Health and Safety Code and in subdivision (e) of Section 10700 of this code.

(h) "Eligible employee" means any permanent employee who is actively engaged on a full-time basis in the conduct of business of the employer or small employer and, who has satisfied any employer or small employer waiting period requirements. The term includes sole proprietors or partners of a partnership if they are actively engaged on a full-time basis in the employer's or small employer's business, but does not include employees who work on a part-time, temporary, or substitute basis.

(i) "Employer" means any corporation, partnership, sole proprietorship, or other business entity doing business in this state that may be eligible to participate in a purchasing alliance. The term "employer" shall not include "small employer" as defined in subdivision (s).

(j) "Enrollee" means an eligible employee or a dependent of an eligible employee who is enrolled in a health benefit plan or ancillary benefit plan offered through the purchasing alliance by a participating carrier.

(k) "Health benefit plan" means a policy or contract written or administered by a participating carrier that arranges or provides health care benefits for the covered eligible employees of an employer or small employer and their dependents. The term does not include accident only, credit, dental, vision, disability income, or long-term care insurance, coverage issued as a supplement to liability insurance, automobile medical payments insurance, or insurance under which benefits are payable with or without regard to fault and is statutorily required to be continued in any liability insurance polic or equivalent self-insurance.

(*l*) "Management company" means the company under contract to the purchasing alliance to provide managerial services for the operation of the purchasing alliance.

(m) "Participating carrier" means a carrier that contracts with a purchasing alliance to provide coverage to enrollees under a health benefit plan or ancillary benefit plan.

(n) "Participating employer" means an employer or small employer who contracts with a purchasing alliance to provide coverage to the employer's or small employer's employees.

(o) "Purchasing alliance" means a non-risk-bearing entity issued a certificate of registration pursuant to this chapter to provide health benefits through multiple unaffiliated participating carriers to multiple participating employers, small employers and their employees within this state as authorized by the commissioner. That entity shall include nonprofit corporations, for-profit corporations, trusts, partnerships, and sole proprietorships.

(p) "Risk adjustment factor" for small employer benefit plan designs and contracts has the same meaning as in subdivision (j) of Section 1357 of the Health and Safety Code and in subdivision (u) of Section 10700 of this code.

(q) "Service region" means that portion of the state, designated by the commissioner pursuant to regulations as described in this chapter in which each purchasing alliance must fairly and affirmatively offer, market, and sell all of the health benefit plan designs offered through the purchasing alliance that are sold or offered to a small employer to all small employers.

(r) "Small employer" has the same meaning as in paragraph (1) of subdivision (*l*) of Section 1357 of the Health and Safety Code and in paragraph (1) of subdivision (w) of Section 10700 of this code.

(s) "Third-party administrator" means the company contracted by the purchasing alliance to provide administrative services for the purchasing alliance and that is licensed to provide those services by the department pursuant to Section 1759.10.

Article 3. Regulation

10820. (a) The commissioner shall regulate the establishment and conduct of purchasing alliances as set forth in this chapter.

(b) No person or entity may market, sell, offer, or contract for a package of one or more health benefit plans underwritten by two or more carriers to two or more employers or small employers or their eligible employees within a purchasing alliance without first being registered by the commissioner pursuant to this chapter. This subdivision does not apply to entities licensed by the Department of Corporations as health care service plans or entities licensed by the Department of Insurance as disability insurers except that no licensed health care service plan or licensed disability insurer may be registered with the commissioner as a purchasing alliance. This chapter does not apply to any entity exempt pursuant to Section 1349.2 of the Health and Safety Code.

87

(c) A person or entity not registered by the commissioner as a purchasing alliance and engaged in the purchase, sale, marketing or distribution of health insurance or health care benefit plans shall not hold itself out as an alliance, health insurance purchasing alliance, purchasing alliance, health alliance, health insurance purchasing cooperative, or purchasing cooperative, or otherwise use a confusingly similar name.

(d) The commissioner shall establish six geographic service regions throughout which all purchasing alliances shall operate. These regions shall be established with no region smaller than an area in which the first three digits of all its postal ZIP Codes are in commo within a county and shall divide no county into more than two service regions. Geographic service regions established pursuant to this section shall, as a group, cover the entire state, and the areas encompassed in geographic service regions shall be separate and distinct from regions encompassed in other geographic service regions. Geographic service regions may be noncontiguous.

(e) Nothing in this chapter shall be deemed to be in conflict with or limit the duties and powers granted to the commissioner under the laws of this state.

(f) Purchasing alliances shall report to the commissioner any suspected or alleged law violations of this chapter.

(g) Violations of this chapter shall be subject to the penalties outlined hereafter.

(h) The commissioner shall adopt reasonable rules and regulations as are necessary to administer this chapter.

(i) Nothing in this chapter shall be construed or interpreted to apply to an entity that has been approved by the Commissioner of Corporations, pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, to act as a solicitor and third-party administrator with respect to a multiple carrier or health care service plan marketing cooperative in which each carrier or health care service plan contracts directly with subscribing groups or individuals for the provision of health care, for the arranging for the provision of health care, or for the provision of coverage for health care.

10821. (a) An entity seeking to obtain a certificate of registration to act as a purchasing alliance shall complete and file with the commissioner an application designated by the commissioner. An application will not be deemed filed until all information necessary to properly process the application has been received by the commissioner.

(b) Upon filing, the commissioner shall make a determination concerning the application and provide notice of file determination to the applicant within 180 days of the date the application is deemed filed. If approved, a copy of a certificate of registration, in a form designed by the commissioner, shall be provided to the purchasing

alliance. The certificate of registration shall serve as authorization t operate pursuant to this chapter.

(c) A purchasing alliance shall maintain a minimum net worth of forty thousand dollars ($40,000) plus one months operating expenses as reserves. Net worth is defined as the excess of admitted assets over all liabilities.

(d) A purchasing alliance shall at all times maintain current assets of at least ten thousand dollars ($10,000) in excess of current liabilities, as such current assets and liabilities may be defined pursuant to regulations made by the commissioner. In making those regulations, the commissioner shall be guided by generally accepted accounting principles followed by certified public accountants in this state.

(e) The entity that is seeking to obtain a certificate of registration to act as a purchasing alliance shall file with the commissioner the following information or documents:

(1) At the time of initial registration, the entity shall provide a written description as to how the entity intends to meet the public policy objectives of increased access and improved quality of health care services.

The written description shall also demonstrate that the purchasing alliance will have the technical expertise and physical capacity to serve employers or small employers and their eligible employees in this state.

The written description shall also describe the scope of services to be offered in this state and the resources and expertise to be used to implement and administer those services.

(2) Current partnership agreements, articles of incorporation, trust documents, or similar documents establishing the group.

(3) Current bylaws of the group.

(4) A statement of grievance procedures relative to the eligibility, enrollment, premium collection, and administrative services provided by the alliance.

(5) A statement of enrollment procedures and requirements, including participation and contribution rules and requirements.

(6) A statement of disenrollment criteria and procedures.

(7) A statement of payment procedures, late payment procedures, and grace periods.

(8) A purchasing alliance shall demonstrate to the satisfaction of the commissioner that its governance makes it an appropriate and effective representative of employers or small employers and their eligible employees' interests throughout this state. A purchasing alliance shall organize and facilitate competition between multiple unaffiliated carriers.

(9) A list of owners, partners, officers, and directors of the applicant and the contracted management company or third-party administrator, if such are employed, and personal biographical

information or firm descriptions for each. The owners, partners, officers, directors, and contracted managers and administrators shall not have a prior record of administrative, civil, or criminal violations within any financial service industry.

The personal biographical information and firm descriptions shall demonstrate by clear and convincing evidence that those involved in the operation of the alliance have the expertise, experience, and character to effectively and professionally represent employers or small employers and their eligible employees in a fiduciary capacity.

(10) Evidence of adequate security and prudence in the accounting, deposit, collection, handling, and transfer of moneys. A purchasing alliance shall affirmatively demonstrate adequate financial controls to the satisfaction of the commissioner as a condition of being issued a certificate of registration.

(11) A description of the employers or small employers and their eligible employees to which the purchasing alliance will be marketing. A purchasing alliance shall demonstrate to the satisfaction of the commissioner that it will fairly and affirmatively offer, market, and sell all of its available small employer health benefit plan products to all small employers throughout all the service regions in this state.

(12) Disclosure of any preexisting oral or written agreements.

(13) Any other information required by the commissioner deemed pertinent to the policies and operation of the alliance.

(f) Thirty days prior to any amendment or modification to any of the documents submitted pursuant to subdivision (e), the alliance shall file with the commissioner a copy of the amended or modified document. Any amendment or modification shall be deemed approved if the commissioner has not disapproved the document within 30 days.

10821.5. (a) The purchasing alliance shall furnish an annual financial audit to the commissioner on the forms provided by the commissioner. The annual financial audit may be filed either on a calendar year basis on or before March 31, or, if approved in writing by the commissioner in respect to any individual purchasing alliance, on a fiscal year basis on or before 90 days after the end of the fiscal year. The deadline for filing the annual audit may be extended by the commissioner for good cause, as determined by the commissioner for a period not to exceed 60 days. Failure to submit an audit on time, or within any extended time that the commissioner may grant, shall be grounds for an order by the commissioner to prohibiting the alliance from accepting any new business pursuant to this section. The audits shall be private, except that a synopsis of the balance sheet on a form prescribed by the commissioner may be made available to the public upon request. The audits shall be conducted and prepared in accordance with generally accepted auditing standards by an independent certified public accountant or independent licensed

public accountant whose certification or license is in good standing at the time of the preparation. The fee for filing of the audit shall be three hundred thirteen dollars ($313). Any purchasing alliance that fails to file any audit or other report on or before the date it is due shal pay to the commissioner a penalty fee of one hundred eighteen dollars ($118) payable within 30 days of the due date of the audit and on failure to pay that fine or any fee or file the audit required by this section, shall forfeit the privilege of accepting new business until the delinquency is corrected. The commissioner may refuse to accept an audit or order a new audit for any of the following reasons:

(1) Adverse result in any proceeding before the state board of accountancy affecting the auditor's license.

(2) The auditor has an affiliation with the purchasing alliance or any of its officers or directors which could prevent his or her reports on the purchasing alliance from being reasonably objective.

(3) The auditor has been convicted of any misdemeanor or felony based on his or her activities as an accountant.

(4) Judgment adverse to the auditor in any civil action finding him or her guilty of fraud, deceit, or misrepresentation in the practice of his or her profession.

(b) Financial and performance audits or examinations of the purchasing alliance shall be conducted by the commissioner once every two years. The cost of the examinations or audits are to be paid by the purchasing alliance. The commissioner may impose conditions on registration, or continued registration to remedy compliance or performance problems.

(c) At any time the commissioner determines, after notice and hearing, that a purchasing alliance registered under this article has willfully failed to comply with any of the provisions of this section, the commissioner shall make his or her order prohibiting the purchasing alliance from conducting its business for a period not to exceed one year.

Any purchasing alliance violating an order made under this subdivision is subject to seizure under Article 14 (commencing with Section 1010) of Chapter 1 of Part 2 of Division 1, is guilty of a misdemeanor, and may have its certificate of registration revoked by the commissioner. Any person aiding and abetting any purchasing alliance in violation of that order is guilty of a misdemeanor.

The purpose of this section is to maintain the solvency of the purchasing alliance subject to this article and to protect the public by preventing fraud and requiring fair dealing. The audit shall be designed to ensure that the purchasing alliance is not a risk-bearing entity, to ensure sound financial controls and money management, and to prevent mismanagement or misappropriation of funds either through neglect or malfeasance. In order to carry out those purposes the commissioner shall make reasonable rules and regulations to

govern the conduct of the business of the purchasing alliance subject to this chapter.

(d) The commissioner shall establish fees for initial registration of a purchasing alliance and for renewal of registration of a purchasing alliance in an amount sufficient to cover the costs of administering this chapter. A purchasing alliance shall pay the initial registration fee at the time of application for registration, and the renewal fee at the time of application for renewal.

10822. After the issuance or reissuance of a certificate of registration to act as a purchasing alliance, the holder shall continue to comply with the requirements as to its business set forth in this chapter and in the other applicable sections of this code, and in the other laws of this state.

10823. In addition to any other grounds specified in this chapter, the following constitute grounds for denial, nonrenewal, suspension, or revocation of an application or existing certificate of registration, following notice and an opportunity for hearing:

(a) Failure to comply with the provisions of this chapter.

(b) Failure to disclose a preexisting oral or written agreement during the alliance application process.

(c) Failure to fairly and affirmatively offer, market, and sell all of the health benefit plan designs offered through a purchasing alliance that are sold or offered to small employers to all small employers.

(d) Failure to have adequate controls or failure to follow approved procedures.

(e) Failure to meet minimum standards in a financial or performance audit or examination.

(f) Failure to comply with a lawful order of the commissioner.

(g) Committing an unfair or deceptive act or practice as defined in Section 17200 of the Business and Professions Code or under Chapter 6.5 (commencing with Section 790) of Part 2 of Division 1.

(h) Filing any necessary form with the commissioner that contains fraudulent information or omission.

(i) Misappropriation, conversion, illegal withholding, or refusal to pay over upon proper demand any moneys that belong to a person or participating carrier otherwise not entitled to the alliance and that have been entrusted to the alliance in its fiduciary capacity.

(j) Operation of the purchasing alliance that is at variance with the basic organizational documents as filed pursuant to this chapter or as published by the purchasing alliance, or in any manner contrary to that described in, or reasonably inferred from, the purchasing alliance's application for certification and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the commissioner pursuant to this chapter.

(k) The continued operation of the purchasing alliance will constitute a substantial risk to its subscribers and enrollees.

87

(*l*) The purchasing alliance has violated, attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter or any rule or regulation adopted by the commissioner pursuant to this chapter.

(m) The purchasing alliance has permitted, or aided or abetted, any violation by an employee or contractor who is a holder of any license, certificate, permit, or registration issued pursuant to the Business and Professions Code, the Health and Safety Code, or this code, which violation would constitute grounds for discipline against that licensee, or certificate, permit, or registration holder.

(n) The purchasing alliance has aided, abetted, or permitted the commission of any illegal acts.

(o) The purchasing alliance, its management company, or any other affiliate of the purchasing alliance, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the purchasing alliance, management company, or affiliate, has been convicted or pleaded no contest to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of that person under this chapter. The commissioner may revoke or deny a certificate issued under this chapter irrespective of a subsequent order under Section 1203.4 of the Penal Code.

10824. (a) The commissioner may take disciplinary action against a purchasing alliance if the commissioner determines that the purchasing alliance has committed any of the acts set forth in Section 10823. The disciplinary action may include censuring the purchasing alliance, or prohibiting for a period not exceeding 24 months or barring permanently, a person, partnership, corporation, or trust from acting as a purchasing alliance.

(b) The commissioner shall notify the purchasing alliance of any order that suspends or bars a person from engaging in operations as a purchasing alliance. It shall be unlawful for any purchasing alliance, after receipt of notice of the order, to enroll any new employers or small employers.

(c) The commissioner may prohibit any person from serving as an officer, director, employee, or associate of any purchasing alliance or solicitor firm of any purchasing alliance, or any management company of any purchasing alliance, or as a solicitor or agent if any of the following applies:

(1) The prohibition is in the public interest and the person has committed or caused, participated in, or had knowledge of, and failed to properly report a violation of this chapter by a purchasing alliance, management company, or solicitor firm.

(2) The person was an officer, director, employee, associate, or provider of a purchasing alliance or of a management company or

solicitor firm of any purchasing alliance whose certificate has been suspended or revoked pursuant to this section and the person had knowledge of and failed to report, or participated in, any of the prohibited acts for which the certificate was suspended or revoked.

(3) The person was an officer director, employee, or associate of a purchasing alliance that has been the subject of an order of suspension or bar from engaging in operations as a purchasing alliance under this section and the person had knowledge of, or participated in, any of the prohibited acts for which the order was issued. A proceeding for the issuance of an order under this subdivision may be included with a proceeding against a purchasing alliance under this section, or may conduct a separate proceeding.

(4) The person has been convicted or pleaded no contest to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of the person under this chapter.

(d) Any disciplinary action under Section 10823 and this section shall be conducted in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

10825. (a) A purchasing alliance whose certificate has been revoked or suspended for more than one year may petition the commissioner to reinstate the certificate as provided by Section 11522 of the Government Code. No petition may be considered if the petitioner is under criminal sentence for a violation of this chapter, or for any offense that would constitute grounds for discipline or denial of registration under this chapter, including any period of probation or parole.

(b) A purchasing alliance that is barred or suspended for more than one year from acting as such, or that is subject to an order imposing discipline that by its terms is effective for more than one year, may petition the commissioner to reduce by order the penalty in a manner generally consistent with the provisions of Section 11522 of the Government Code. No petition may be considered if the petitioner is under criminal sentence for a violation of this chapter, or for any offense that would constitute grounds for discipline or denial of registration under this chapter, including any period of probation or parole.

(c) The petition for restoration shall be in the form prescribed by the commissioner and the commissioner may condition the granting of the petition on any additional information and undertakings that the commissioner may require in order to determine whether the purchasing alliance, if restored, would engage in business in full compliance with the objectives and provisions of this chapter and the rules and regulations adopted by the commissioner under this chapter.

(d) The commissioner may prescribe a fee not to exceed one thousand dollars ($1,000) for the filing of a petition for restoration pursuant to this section. In addition, the commissioner may condition the granting of the petition to a purchasing alliance upon payment of the assessment due and unpaid as of December 15 during the preceding 12-calendar-month period, and if the purchasing alliance's suspension or revocation was in effect for more than 12 months, upon the filing of a new application for registration as a purchasing alliance and the payment of the fee for certification.

10826. (a) Any person who violates any provision of this chapter, or who violates any rule or order adopted or issued pursuant to this chapter, shall be liable for a civil penalty not to exceed two thousand five hundred dollars ($2,500) for each violation, which shall be assessed and recovered in a civil action brought in the name of the people of the state by the commissioner in any court of competent jurisdiction.

(b) As applied to the civil penalties for acts in violation of this chapter, the remedies provided by this article and by other sections of this chapter are not exclusive, and may be sought and employed in any combination to enforce this chapter.

(c) No action may be maintained to enforce any liability created under article unless brought before the expiration of four years after the act or transaction constituting the violation.

(d) The commissioner shall be able to recover the costs of investigating an alleged violation of this chapter in which a violation has been determined.

Article 4. Conflicts of Interest

10830. No owner, officer, partner, or board members or members of their household nor any management personnel of the alliance may be employed by, be a consultant for, be a member of the board of directors of, be affiliated with an agent of, or otherwise be a representative of any carrier or other insurer, agent or broker, or a health care provider. This provision shall not preclude any of the above from purchasing coverage through an alliance.

Any employee of a purchasing alliance and any person or organization having any ownership interest in a purchasing alliance or any organization the alliance contracts with for marketing purposes shall be prohibited from receiving compensation based upon the health status, claims experience, industry, occupation, or geographic location of participating employers or small employers or the participating employer's or small employer's employees exclusive of a compensation arraignment that provides compensation on the basis of a percentage of premium, provided that the percentage shall not vary because of health status, industry, occupation, medical utilization, claims experience, or geographic

location within a service region. Those employees, persons, and organizations are expressly prohibited from receiving compensation based upon a participating carrier's loss ratio resulting from the carrier's participation in the purchasing alliance.

Additionally, any employee of a purchasing alliance and those persons or organizations having an ownership interest in the purchasing alliance shall be prohibited from encouraging or directing employers or small employers to seek coverage from a source other than the alliance because of the health status, claims experience, industry, occupation, or geographic location of the employer or small employer or the employer's or small employer's employees.

Article 5. Additional Powers of and Restrictions on Purchasing Alliances

10840. A purchasing alliance shall do all of the following:

(a) Set reasonable fees, which may vary by employer or small employer size, in the purchasing alliance that will finance reasonable and necessary costs incurred in marketing, selling, servicing, and administering the purchasing alliance. Fees may not vary based upon the small employer or his or her enrollees and dependents' actual or expected health status, medical utilization, claims experience, industry, occupation, or the geographic location of participating small employers within the same service region.

(b) Define, market, offer, and sell to small employers the health benefit plans purchased from participating carriers. The purchasing alliance may also incidentally offer optional ancillary benefit plans. The purchasing alliance may also define, market, and offer health benefit plans and ancillary benefit plans to employers.

(c) Require as a condition of participation that all employers or small employers include all their eligible employees or a minimum percentage of eligible employees in coverage purchased through the purchasing alliance.

(d) With respect to small employers, the purchasing alliance shall require that the application of participation requirements be uniformly applied to all small employers.

(e) Provide premium collection services for health benefit plans and ancillary benefit plans offered through the purchasing alliance.

(f) Establish administrative and accounting procedures for operating the purchasing alliance and for services to employers and small employers and enrollees, including billing, administration, underwriting, marketing, enrollment, sales, regulatory compliance, and ensuring carrier and member compliance with the purchasing alliance requirements.

(g) Establish rules, conditions, and procedures for participating members. The rules, conditions, and procedures for participating small employers shall be uniformly applied.

(h) Establish rules, conditions, and procedures for participating carriers.

(i) Reject or allow a participating carrier to reject an employer or small employer from participation or drop or allow a participating carrier to drop a participating employer if the participating employer or any of its eligible employees fail to pay premiums, or if the participating employer fails to maintain the minimum participation and contribution requirements or if the participating employer has engaged in fraud or material misrepresentation in connection with a health benefit plan or ancillary benefit plan purchased through the purchasing alliance. If a participating employer or enrollee is dropped from coverage, the enrollee shall be entitled to continuation and conversion coverage to the extent provided for under applicable state or federal continuation laws and the state conversion law.

(j) Contract with at least three unaffiliated participating carriers offering health benefit plans to provide benefits in all regions of the state in which each carrier is licensed to operate and together to provide health benefit plans throughout all service regions in this state to ensure that enrollees have a personal choice from among a reasonable number of competing carriers. The commissioner may, upon a showing of good cause, waive the requirement to have at least three unaffiliated participating medical carriers.

(k) Fairly and affirmatively offer, market, and sell all the health benefit plans sponsored by the purchasing alliance that are sold or offered to small employers to all small employers, in all service regions. In addition, the alliance shall require all participating carriers to make their purchasing alliance products available in all portions of each of the alliances service regions where the carrier offers health care benefits.

(*l*) Be registered to operate in all service regions in this state and throughout each service region.

(m) Develop standard enrollment procedures.

(n) Publish educational materials, plan descriptions, and comparison sheets describing participating carriers and the benefit plan designs available through the purchasing alliance for use in enrolling employers or small employers and their eligible employees. The information may include an assessment of utilization management procedures and the level of quality and cost-effective care.

(o) Establish conditions for participation of employers or small employers that conform to the requirements of this chapter and that include, but are not limited to, assurances that the employer or small employer is a bona fide employer or small employer group and

provision for prepayment of premiums or other mechanisms to ensure that payment will be made for coverage. Conditions for participating small employers shall be uniformly applied to all small employers.

(p) Provide that each eligible employee may choose from any participating medical carrier as long as the participating carrier provides coverage where the employee works or lives.

(q) Receive, review, and act, as appropriate, on grievances by participating employers or enrollees.

(r) Review information and recommendations from consumers, employers, small employers, participating carriers, health care providers, and other sources. After the review, the board may issue reports or otherwise make recommendations to improve the delivery or purchase of health care.

(s) Establish administrative and accounting procedures for operating the purchasing alliance and for providing services to employers, small employers, and enrollees.

(t) Prepare an annual report on the operations of the purchasing alliance to the commissioner, which shall include an accounting of all outside revenues received by the board and internal and independent audits and any other information the commissioner may require.

(u) Establish procedures for billing and collection of premiums from employers and small employers, including any share of the premium paid by enrollees.

(v) Establish procedures for annual open enrollment periods during which an employee enrolled in a health benefit plan through the purchasing alliance may elect to enroll in any health benefit plan that is available to that size group through the purchasing alliance, and that provides health coverage where the employee lives or works and during which any enrollee may elect to enroll in any health benefit plan that is available to that size group through the purchasing alliance, and that provides health coverage where the enrollee lives or works. For purposes of this subdivision, "size group" refers to whether the employer is a small employer or any other employer covered by this chapter.

(w) Provide that in the event an employer or small employer terminates coverage purchased through the purchasing alliance, the former employer or small employer shall be ineligible to purchase a health benefit plan or ancillary benefit plan through the purchasing alliance for a period determined by the alliance, but not to exceed 12 months.

(x) Maintain a trust account or accounts in a California bank for deposit of all moneys received and collected for operation of the purchasing alliance. A purchasing alliance, its owners, operators, partners, board members, employees, and agents shall have a fiduciary duty with respect to all moneys received or owed to it to

87

ensure payment of its obligations and a full accounting to its participating employers, health plans, and the commissioner.

(y) With respect to small employers, ensure that all carrier rates for purchasing alliance small group health benefit plans are consistent with the requirements of Sections 1357.12 and 1357.13 of the Health and Safety Code and Sections 10714 and 10715.

(z) Treat all members within an employer or small employer group equally with regard to administrative fees and benefits of participation.

(aa) Every purchasing alliance shall offer at least one health plan that compensates its providers on an other than capitated basis in every region in which the alliance operates.

(ab) Have the authority to develop or contract for the development of uniform standards for data to be provided by participating carriers and providers. The purchasing alliance may collect or contract for the collection of data necessary for evaluation of the performance of participating carriers and their provider networks by consumers, providers, employers, small employers, and the commissioner. In formulating data collection standards, the board may use standards based on, and consistent with, existing state, National Association of Insurance Commissioners, and national health care data collection initiatives, and shall take into account their feasibility and cost-effectiveness.

(ac) Not expend for administrative purposes and profits in any fiscal year an excessive amount of the aggregate premiums, fees, and other periodic payments received by the purchasing alliance for providing health benefits to employers, small employers, and their employees, through a contract with participating carriers. As used in this subdivision, "administrative costs" includes costs in connection with marketing and sales of the health benefit plans offered by the purchasing alliance.

(ad) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this chapter.

10841. (a) A purchasing alliance shall comply with all requirements pertaining to the underwriting, rating and renewal practices for small employers, pursuant to subdivisions (a) and (b) of Section 1357.12 of the Health and Safety Code and subdivisions (a) and (b) of Section 10714.

(b) A purchasing alliance shall comply with all requirements pertaining to the marketing practices for small employers who participate in the purchasing alliance, pursuant to subdivision (d) of Section 1357.03 of the Health and Safety Code and subdivision (f) of Section 10705.

(c) A purchasing alliance shall comply with all requirements pertaining to the participation requirements for small employers who participate in the purchasing alliance, pursuant to subdivision

87

(b) of Section 1357.03 of the Health and Safety Code and Section 10706. A carrier participating in a purchasing alliance shall be deemed to be in compliance with this requirement.

10842. A purchasing alliance may do any of the following:

(a) Contract with qualified independent third parties for any services necessary to carry out the powers and duties authorized or required by this chapter.

(b) Employ necessary staff.

(c) Sue or be sued, including taking any legal actions necessary or proper for recovering any penalties for or on behalf of the health insurance purchasing group.

(d) Allow a participating employer to choose the benefit plan design, from those offered by the purchasing alliance, to be made available to their eligible employees.

(e) Allow eligible employees to enroll in any benefit plan design offered by the purchasing alliance.

(f) Contract with licensed insurance agents or brokers to market and service coverage made available through the purchasing alliance to its members. Compensation for agents and brokers may not vary based on the small employer or his or her enrollees and dependents' actual or expected health status, industry, occupation, medical utilization, claims experience, or geographic location within the service region. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium; provided that percentage shall not vary because of the health status, industry, occupation, medical utilization, claims experience, or geographic location within the service region.

(g) Exclude a carrier or freeze enrollment in a carrier for failure to achieve established quality, access, or information reporting standards of the purchasing alliance.

10843. A purchasing alliance shall not do any of the following:

(a) Purchase health care services, assume risk for the cost or provision of health services, or otherwise contract with health care providers for the provision of health care services directly to enrollees.

(b) Exclude a small employer or eligible employee or dependent of an eligible employee of a small employer from membership in the purchasing alliance who agrees to pay fees for membership and the premium for coverage through the purchasing alliance and who abides by the bylaws and rules of the purchasing alliance.

(c) Prohibit the participation of small employers, as described in subdivision (a) of Section 1357.03 of the Health and Safety Code and in subdivision (b) of Section 10705, or utilize risk adjustment practices that conflict with the small employer group health provisions described in subdivisions (a) and (b) of Section 1357.12 of the Health and Safety Code and subdivision (b) of Section 10714.

87

(d) Charge a fee not directly related to the operation of the purchasing alliance.

(e) As a condition of participation, require an employer or small employer, eligible employee or dependent to subscribe to nonhealth care or nonhealth insurance related products or services.

(f) Operate the purchasing alliance or market the purchasing alliance in a service region in a way that would cause the purchasing alliance to select a risk pool with health care utilization that is significantly below the average for all similar groups with similar coverage in the same region.

(g) Engage in any competitive act or practice that results in the selection of small employers and his or her enrollees and dependents based on actual or expected health status, claims experience, medical utilization, industry, occupation, or geographic location within the service region.

(h) Require or take any action inconsistent or in conflict with state laws or regulations.

10845. (a) The commissioner shall require every purchasing alliance, as a condition precedent to receiving and holding a certificate of registration, to file and maintain in the commissioner's office a writing designating an agent for service of process. The writing shall state the name of the agent and his or her place of business in this state with sufficient particularity so that he or she can readily be found by peace officers or process servers. Appointment of the agent reasonably available for service of papers, notice, proof of loss, summons or other process during business hours shall be continuously maintained by every registered purchasing alliance subject to this article while it holds a valid and unrevoked certificate of registration.

(b) An agent designated by a purchasing alliance as provided in this article may file with the commissioner a written statement of resignation as that agent, which shall be signed and execution thereof shall be duly acknowledged by the agent. Thereupon, the authority of the agent to act in such capacity shall cease and the commissioner shall forthwith give written notice of the resignation by mail to the purchasing alliance addressed to its principal office as shown by the commissioner's records. If an agent who has been appointed by a purchasing alliance as provided by this article dies or resigns or removes his or her residence from the state, the purchasing alliance shall forthwith file with the commissioner an appointment of a new agent on a form provided by the commissioner for such purpose and pay the filing fee therefor, and the filing shall be deemed to revoke any prior designation of agent.

(c) No fee shall be charged, except as included in the application for certificate of registration fee provided in this article, for filing the initial appointment under this article by an applicant for registration. Thereafter the commissioner shall require the payment of forty-five

87

dollars ($45) in advance as a fee for filing appointment of agent or stipulation or both by every registered purchasing alliance.

Article 6. Participating Carriers

10850. (a) In order to be eligible to be a participating carrier, a carrier shall demonstrate the following operating characteristics satisfactory to the board:

(1) Be licensed and approved as a carrier and in good standing with the appropriate regulatory authority.

(2) The ability to provide data required by the board, including information on enrollee satisfaction based on standard surveys, as may be prescribed, and to meet reasonable satisfaction measures as may be established.

(3) The ability to provide standard data elements in a manner prescribed by the board.

(4) All other criteria established by the board.

(b) Carriers that contract with or employ health care providers shall have mechanisms to accomplish all of the following in a manner satisfactory to the purchasing alliance, provided that the requirements of the alliance do not conflict with the carrier's licensing requirements:

(1) Review the quality of care covered.

(2) Review the appropriateness of care covered.

(3) Provide accessible health care services.

(c) In evaluating which carriers may participate in the purchasing alliance, the board shall consider all of the following:

(1) Minimum geographic service and participation requirements, maximum thresholds for premium rates, and standards for determining whether a carrier operates efficiently.

(2) The ability of a carrier to provide services within the purchasing alliance service regions.

(3) Pricing and the competitiveness of each bid from a carrier.

10851. Every participating carrier shall:

(a) Meet the standards established by the board pursuant to this chapter.

(b) Provide any data required by the board.

(c) Comply with, all applicable laws and regulations that regulate health care coverage or medical benefits provided to employers, including, with respect to coverage that is provided to small employers, Chapter 8 (commencing with Section 10700) for insurers and Article 3.1 (commencing with Section 1357) of Chapter 2.2 of Division 2 of the Health and Safety Code for health care service plans. However, a carrier contracting to participate in a purchasing alliance shall be deemed to be in compliance with the requirements for small employers of subdivision (a) of Section 1357.03 of the Health and Safety Code and of subdivisions (b) and (c) of Section 10705 for a

87

benefit plan design offered through the purchasing alliance in those service regions in which the carrier participates in the purchasing alliance and the benefit plan design is offered exclusively through the purchasing alliance.

(d) Comply with all rules and regulations regarding the application of risk adjustment factors to standard risk rates for small employers as specified in subdivisions (a) and (b) of Section 1357.12 of the Health and Safety Code and subdivisions (a) and (b) of Section 10714 of this code. A participating carrier shall also comply with the requirements that coverage be issued to small employers on a guaranteed issue basis as is specified in subdivision (a) of Section 1357.03 of the Health and Safety Code and subdivision (b) of Section 10705 of this code for small employers.

(e) All participating medical carriers shall, in determining small employer rates for health benefit plans offered through a purchasing alliance, use the six service regions established by this chapter in determining risk categories for standard employee risk rates.

(f) Enroll and disenroll individuals as directed by the purchasing alliance or its designee.

(g) Comply with any other requirement established by the board pursuant to this chapter.

10853. In contracts with participating carriers, the purchasing alliance may establish performance standards for specific contractual elements and penalties for failure to fulfill specific contractual obligations.

10854. Nothing in this chapter shall prohibit a participating carrier from contracting with particular health care providers or types, classes, or categories of health care providers or setting reimbursement methodology.

10855. In the event the participating carrier elects to terminate its participating agreement with a purchasing alliance, the participating carrier shall do both of the following:

(a) Provide advance notice of its decision to the board.

(b) Provide notice of the decision at least 180 days prior to the nonrenewal of any health benefit plan or ancillary benefit plan to employers or small employers and enrollees.

A participating carrier that elects not to renew a health benefit plan with a purchasing alliance shall be prohibited from writing new business through the purchasing alliance for a period of three years from the date of the notice to the purchasing alliance or until the purchasing alliance, with the concurrence of the commissioner, invites the former participating carrier to renew participation, whichever is sooner.

10856. Nothing in this article shall be construed to limit the existing regulatory authority of the Department of Corporations to regulate health care service plans or of the Department of Insurance to regulate disability or life insurers or hospital service plans. None

of the requirements of this article shall conflict with the participating carrier's licensing requirements.

Article 7. Contracts with Employers, Small Employers, and Participating Carriers

10860. Contracts between the purchasing alliance and participating carriers shall specify how all premiums will be transmitted, and penalties and grace periods for payments.

10861. Contracts between purchasing alliances and participating employers shall provide all of the following:

(a) For administrative purposes, the purchasing alliance shall be the policyholder or contractholder of the health benefit plan or ancillary benefit plan on behalf of participating employers, their eligible employees, and dependents.

(b) That the participating carrier will issue a certificate of coverage, or equivalent document, specifying the essential features of the health benefit plan's or ancillary benefit plan's coverage to each enrolled eligible employee.

(c) The following notice shall be provided to employers, small employers, and eligible employees who obtain coverage from a purchasing alliance at the time of enrollment:

NOTICE

(1) THE PURCHASING ALLIANCE IS NOT AN INSURANCE COMPANY AND DOES NOT PAY BENEFITS OR CLAIMS. IT COLLECTS AND DISTRIBUTES PREMIUMS IN YOUR EMPLOYER'S BEHALF TO INSURERS WHO MAY PARTICIPATE IN A GUARANTEE FUND CREATED BY CALIFORNIA LAW. THE ALLIANCE ITSELF DOES NOT PARTICIPATE IN A GUARANTEE FUND CREATED BY CALIFORNIA LAW.

(2) THE PURCHASING ALLIANCE WHICH YOUR EMPLOYER HAS JOINED IS REGISTERED BY THE CALIFORNIA DEPARTMENT OF INSURANCE TO PROVIDE SPECIFIC ADMINISTRATIVE SERVICES AND MAY NOT ASSUME ANY RISK FOR CLAIM AND BENEFIT PAYMENTS.

(3) FOR ADDITIONAL INFORMATION ABOUT THE PURCHASING ALLIANCE YOU SHOULD ASK QUESTIONS OF YOUR BENEFITS ADMINISTRATOR OR YOU MAY CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT 1-800-927-4356.

87

Article 8. Marketing

10870. The board shall establish marketing standards to be used by participating carriers.

10871. Any marketing, advertisement, or educational material for health benefit plans or ancillary benefit plans sold through the purchasing alliance shall be approved by the board prior to its use.

10872. This article shall not be construed to prohibit or to compel the purchasing alliance or a participating carrier from using the services of an agent or broker.

10873. (a) A participating carrier, agent, broker, contractor, or producer of a participating carrier, or independent insurance agent, broker, contractor, or producer may not engage, directly or indirectly, in an activity or marketing practice that would encourage small employers or eligible enrollees to do any of the following:

(1) Refrain from enrolling in a health benefit plan offered through the purchasing alliance because of their health status, claims experience, industry, occupation, or geographic location within the service region.

(2) Seek coverage from other participating carriers because of their health status, claim experience, industry, occupation, or geographic location within the service region.

(3) Enroll or fail to enroll in the purchasing alliance because of their health status, claims experience, industry, occupation, or geographic location within the service region.

(b) In the event that an agent, broker, contractor, carrier, or producer of a participating carrier fails to abide by these provisions, they shall be subject to the penalties and fines described in Section 10718.

Article 9. Solvency

10880. In the event a purchasing alliance becomes insolvent, the commissioner shall maintain jurisdiction of the alliance for purposes of protection of the interests of the alliance enrollees. In that event, the commissioner may do any of the following:

(a) Arrange for transfer of coverage from the insolvent purchasing alliance to one that is deemed to be solvent by the commissioner.

(b) Arrange for individual employers or small employers participating in the purchasing alliance to obtain coverage through one or more participating carriers outside of an alliance arrangement.

(c) Take any other actions necessary to preserve the coverage provided to employers, small employers, and enrollees in the insolvent alliance.

87

(d) In any proceedings under this article, the costs of employing special deputy commissioners, clerks, or assistants appointed to carry out this article, and all expenses of taking possession of, conversing, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the alliance under this article, shall be fixed by the commissioner, subject to the approval of the court, and shall be paid out of the assets of the alliance to the department.

Article 10. Exemptions

10885. Purchasing alliances shall be exempt from requirements of licensure as a health care service plan or solicitor under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

10886. For purposes of carrier product disclosure, a purchasing alliance shall be considered an entity that provides administrative services, as is described in paragraph (1) of subdivision (d) of Section 10705. As such, a purchasing alliance shall not be required to provide a summary of those plans offered by participating carriers outside of the purchasing alliance with whom they have contracted. A purchasing alliance shall be required to provide a summary brochure of all benefit plan designs that the purchasing alliance offers to employers or small employers.

10887. Except as provided in subdivision (c) of Section 10820, nothing in this chapter shall apply to a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of the Health and Safety Code) when operating within the scope of that license and not contracting with a purchasing alliance registered under this chapter.

10890. The Bureau of State Audits shall conduct an independent review of the cost of health insurance made available through purchasing alliances authorized by this chapter and shall compare the cost of that insurance to actuarially equivalent benefit packages available through the Health Insurance Plan of California in the same rate year.

The bureau shall report its findings in three reports to the Legislature delivered by October 1 of 1997, 1998, and 1999.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative

87

on the same date that the act takes effect pursuant to the California Constitution.

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December 19, 1997

To: Mayor Brown's Blue Ribbon Committee on Universal Health Care

From: Joan Trauner/Colleen Thilgen – PM Squared

Re: Uninsured Program Actuarial Cost Analysis

Introduction

This report details the analyses PM Squared performed to estimate the costs of expanding health care coverage to the uninsured living in the City and County of San Francisco. As requested, this analysis has been conducted independent of any knowledge about proposed financing for the uninsured program. Similarly, there are a number of other factors that have yet to be resolved including exact benefit design, sharing of premium cost by income level, eligibility requirements, program administration and marketing. All of these factors will have an impact on the overall costs for the program.

The size and demographics of the uninsured population in San Francisco are also difficult to estimate. (See separate report from Dr. Andrew Bindman of UCSF/San Francisco General Hospital.) Thus, in the absence of detailed population data, we have made enrollment assumptions about the number of eligible lives, the ratio of working to unemployed enrollees and the ratio of children to adult members. We also have based our assumptions on an HMO benefit package, which is typically less expensive than comprehensive PPO or indemnity benefits, as the basis for our review of benefit costs.

Approach

Top-Down Analysis

In modeling the costs of covering the uninsured in San Francisco, we followed two distinct approaches. The first approach, which we call a *top-down analysis*, compares the current market premium rates for governmental HMO programs offered in the State of California including the Health Insurance Plan of California (HIPC), the California Public Employees' Retirement System (CalPERS) and the San Francisco Health Service System (HSS). The intent of the *top-down analysis* is to derive a market-based premium rate, using existing health benefit packages.

Displayed in Exhibit A are four different HMOs' 1998 single premium rates under the three governmental programs (rates are shown for both the HIPC Standard and Preferred benefit packages). The single rates listed are San Francisco-specific (Area 3 in the HIPC, which also includes the following counties – Alameda, Contra Costa, Marin, San Mateo, Santa Clara). The San Francisco-specific CalPERS rates were derived by adjusting the statewide rates for the San Francisco-specific age/sex factor of PERS' enrollees.

We converted the single premium rates for the plans in Exhibit A to per member per month (PMPM) rates by adjusting for program-specific average family size and population distributions by premium rating tier (e.g., single, two-party, family). This adjustment eliminates any subsidy for family coverage that may have been built into the single rate. The PMPM rates were then adjusted for the age/sex factors and benefit plan differences (relative to the HIPC Standard Plan) to accurately compare the rates.

As shown in Exhibit A, Table 2, the PMPM rates for HMO benefits ranged from a low of $91.75 for Kaiser (HIPC Standard) to a high of $131.82 for PacifiCare (CalPERS). On an adjusted basis, after accounting for age/sex and benefit differences, the PMPM rates ranged from a low of $90.22 for Kaiser (CalPERS) to a high of $113.00 for PacifiCare (HSS), as shown in Exhibit A, Table 6. The important point, in reviewing Table 6, is how closely plan pricing was for three out of four plans in the HIPC, whereas the same plans in CalPERS exhibited a lower premium cost. The bottom-up analysis described in the next section approximated the higher rate structure of the HIPC.

Bottom-Up Analysis

The second approach, which we call a *bottom-up analysis*, follows traditional actuarial methods and relies on utilization and cost assumptions to derive an appropriate PMPM rate. In determining the utilization and cost assumptions used to build-up this rate, we used several data sources including:

- Data from a commercial HMO plan for its members residing in San Francisco
- Data from Bay-Area medical groups/IPAs
- Medi-Cal provider reimbursement rates in San Francisco
- San Francisco County Medi-Cal utilization levels
- Continuance tables derived using PM Squared proprietary data

We modeled the rates under two different benefit packages – HIPC HMO Standard and HIPC HMO Preferred. Exhibit B provides a summary of the differences in benefit plans for HIPC HMO Standard, HIPC HMO Preferred, CalPERS (Basic) and the San Francisco Health Service System. Using continuance tables (i.e., normative claims distributions by dollar size of claim), we valued the benefit plans relative to the HIPC Standard plan. According to our results, the CalPERS Basic plan offers the richest benefit package while the HIPC Standard plan offers the leanest benefit package.

The only difference between the HIPC Standard and HIPC Preferred plans are the level of the copayments. Under the HIPC Standard plan, there is a $100 copayment per hospital admission, $15 copayments for office visits and prescription drug copays of $10 for generic and $15 for brand (assuming a 30-day supply). Conversely, under the HIPC Preferred plan, there is no copayment for hospital admissions, the copayment for office visits is $5 and the prescription drug copays are $5 and $10 for generic and brand, respectively. Both benefit packages offer a fairly limited mental health/substance abuse

benefit and vision care is limited to preventive care for minors. Relative to the HIPC Standard plan, the HIPC Preferred plan is 12-16% more expensive for the employer/purchaser, as shown in Exhibit A, Table 5, due to the differences in copayments.

In our PMPM cost development, we assumed current Medi-Cal level hospital reimbursement rates and set professional rates at 110% - 120% of the current Medicare Resource Based Relative Value Schedule (RBRVS) in San Francisco. Following the factor used for the HIPC, the relative cost per child is calculated as 62% of the cost of covering an adult. Additional assumptions were made regarding 1) the San Francisco uninsured demographic mix, 2) a risk factor as determined using our Marker Diagnoses methodology and 3) a factor for induced demand given that the program will cover a previously uninsured population. The induced demand factor ranges from 4% to 7% depending on service category (e.g., hospital inpatient, professional services, prescription drugs, etc.) and was determined based on the different Marker Diagnoses quotients by geographic sector in San Francisco, using proprietary PM Squared utilization data.

Finally, we added a 15% load for administrative expenses. For HMO products, administrative expenses typically range from 12% - 15% of medical expenses. It is important to note that the flat percentage for administrative expenses assumed in our total cost development will not necessarily correspond to provider capitation payments which reflect other costs such as reinsurance and risk withholds.

Our PMPM estimates developed from the *bottom-up analysis* closely approximate those from the *top-down* review. As shown in Table 6 of Exhibit A, the PMPM net of benefit plan differences relative to the HIPC Standard plan is approximately $110 (with the exception of Kaiser). Since the PMPMs were adjusted for age/sex differences relative to the HIPC, the $110 PMPM reflects the age/sex distribution of the HIPC which is approximately 80% adults and 20% children in San Francisco. In our *bottom-up analysis* scenario for a population consisting of 80% adults and 20% children, we estimated the PMPM rate for the HIPC Standard benefit package to be $115.29 which is roughly equivalent to the $110 rate shown in the *top-down* review adjusted for the induced demand factor. The *bottom-up* PMPM rate for the Preferred HIPC package is $133.74 for the same 80% adult/20% children ratio scenario.

Preliminary Results

We have modeled the total cost analysis under multiple scenarios. These scenarios vary according to the following factors:

- Benefit package (HIPC Standard vs. HIPC Preferred), with and without inpatient hospital services
- Individual annual stop-loss limit (none; $30,000; $50,000)

- Distribution of the number of uninsured adults vs. children (90%/10%; 80%/20%; 60%/40%; 50%/50%; 33%/67%)
- Employer subsidy and member cost-share (20% each; 25% each)
- % of the uninsured population that is employed (50%, 75%, 80%)

Complete sets of tables for all the scenarios developed are available upon request from Tangerine Brigham, San Francisco Department of Public Health.

Based on input from Dr. Andrew Bindman, this report provides cost estimates for the most-likely scenarios, using the following assumptions:

- HIPC Standard and HIPC Preferred benefit packages;
- Distribution of adults at 90% and children at 10%;
- 25% unemployment rate; and
- Employer subsidy/employee cost share for the employed population at 20% and 25%.

As shown in Table 1 below the PMPM cost for the HIPC Standard benefit package is $120.03. At 130,000 eligible lives, the estimated cost for an uninsured program is $187,254,152. If employer subsidies and member cost sharing (for employed individuals) are set at 20% each, then the net cost to the City and County of San Francisco is estimated at $131,077,906. At 25% subsidies/cost sharing, the net cost drops to $117,033,845.

Table 1

Benefit Package	HIPC Standard
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$120.03
Adult Rate PMPM	**$124.78**
Child Rate PMPM	**$77.36**
Total Annual Cost	$187,254,152
Employer Subsidy	20%
Member Cost (Employed Population only)	20%
Annual Uncovered Cost of Benefits	**$131,077,906**

Benefit Package	HIPC Standard
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$120 03
Adult Rate PMPM	**$124.78**
Child Rate PMPM	**$77.36**
Total Annual Cost	$187,254,152
Employer Subsidy	25%
Member Cost (Employed Population only)	25%
Annual Uncovered Cost of Benefits	**$117,033,845**

The HIPC Standard benefit package requires a $15 office copayment and a $100 hospital deductible, which may not be appropriate for a low income population. Conversely, the HIPC Preferred benefit package has a $5 copayment and no hospital deductible but has

considerably higher costs. As shown in Table 2 below, total program costs rise to $217,214,816, with the net cost to the City and County at $152,050,371 assuming 20% cost-sharing and $135,759,260 assuming 25% cost-sharing. In effect, offering the HIPC Preferred benefit package over the HIPC Standard package with either 20% or 25% cost-sharing increases the net annual cost to the City by approximately $19 million to $21 million.

Table 2

Benefit Package	HIPC Preferred
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$139.24
Adult Rate PMPM	**$144.74**
Child Rate PMPM	**$89.74**
Total Annual Cost	$217,214,816
Employer Subsidy	20%
Member Cost (Employed Population only)	20%
Annual Uncovered Cost of Benefits	**$152,050,371**

Benefit Package	HIPC Preferred
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$139.24
Adult Rate PMPM	**$144.74**
Child Rate PMPM	**$89.74**
Total Annual Cost	$217,214,816
Employer Subsidy	25%
Member Cost (Employed Population only)	25%
Annual Uncovered Cost of Benefits	**$135,759,260**

Limited Benefit Package Analysis

Based on a recent discussion in the December 17th meeting of the Actuarial/Data Subcommittee, we have also modeled the cost of the program assuming a more limited benefit package. Specifically, this limited benefit package would be similar to the HIPC Standard or HIPC Preferred packages but would exclude hospital inpatient care (i.e., the hospital inpatient care would revert to the City's safety net providers). The reasoning behind this suggestion was to develop a significantly lower cost offering, while improving access for ambulatory care services.

We modeled four different scenarios for this limited benefit package option, which are displayed in Tables 3 and 4 below. Elimination of an inpatient benefit from the HIPC Standard benefit package reduces the overall cost of the program to $111,862,470 and the net cost to $78,303,729 assuming 20% subsidies and $69,914,044 assuming 25% subsidies. In Table 4, the commensurate numbers for the HIPC Preferred benefit package are shown.

Table 3

Benefit Package	HIPC Standard
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$71.71
Adult Rate PMPM	**$74.54**
Child Rate PMPM	**$46.21**
Total Annual Cost	$111,862,470
Employer Subsidy	20%
Member Cost (Employed Population only)	20%
Annual Uncovered Cost of Benefits	**$78,303,729**

Benefit Package	HIPC Standard
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$71.71
Adult Rate PMPM	**$74.54**
Child Rate PMPM	**$46.21**
Total Annual Cost	$111,862,470
Employer Subsidy	25%
Member Cost (Employed Population only)	25%
Annual Uncovered Cost of Benefits	**$69,914,044**

Table 4

Benefit Package	HIPC Preferred
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$83.18
Adult Rate PMPM	**$86.47**
Child Rate PMPM	**$53.61**
Total Annual Cost	$129,760,465
Employer Subsidy	20%
Member Cost (Employed Population only)	20%
Annual Uncovered Cost of Benefits	**$90,832,326**

Benefit Package	HIPC Preferred
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$83.18
Adult Rate PMPM	**$86.47**
Child Rate PMPM	**$53.61**
Total Annual Cost	$129,760,465
Employer Subsidy	25%
Member Cost (Employed Population only)	25%
Annual Uncovered Cost of Benefits	**$81,100,291**

Additionally, we modeled the costs of the program with a full benefit package but introducing two different individual annual stop-loss limits – $30,000 and $50,000. The cost of care for those exceeding the stop-loss limit in a particular year would revert to the City's safety net providers. When comparing the total numbers in Table 5 below with those in Table 1, it is shown that including a $30,000 annual individual stop-loss limit to the HIPC Standard benefit package trims approximately 9% off the PMPM cost to the plan while including a $50,000 annual individual stop-loss limit to the HIPC Standard package trims approximately 4% off the PMPM cost to the plan.

Table 5

Benefit Package	HIPC Standard
Individual Annual Stop Loss Limit	$30,000
Est. % of Claimants Reaching Stop Loss Limit	0.60%
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$109.69
Adult Rate PMPM	**$114.03**
Child Rate PMPM	**$70.70**
Total Annual Cost	$171,120,418
Employer Subsidy	20%
Member Cost (Employed Population only)	20%
Annual Uncovered Cost of Benefits	**$119,784,293**

Benefit Package	HIPC Standard
Individual Annual Stop Loss Limit	$30,000
Est. % of Claimants Reaching Stop Loss Limit	0.60%
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$109.69
Adult Rate PMPM	**$114.03**
Child Rate PMPM	**$70.70**
Total Annual Cost	$171,120,418
Employer Subsidy	25%
Member Cost (Employed Population only)	25%
Annual Uncovered Cost of Benefits	**$106,950,261**

Benefit Package	HIPC Standard
Individual Annual Stop Loss Limit	$50,000
Est. % of Claimants Reaching Stop Loss Limit	0.24%
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$115.27
Adult Rate PMPM	**$119.83**
Child Rate PMPM	**$74.29**
Total Annual Cost	$179,827,641
Employer Subsidy	20%
Member Cost (Employed Population only)	20%
Annual Uncovered Cost of Benefits	**$125,879,349**

Benefit Package	HIPC Standard
Individual Annual Stop Loss Limit	$50,000
Est. % of Claimants Reaching Stop Loss Limit	0.24%
Total Number of Uninsured	130,000
Assumed Number of Adults	117,000
Assumed Number of Children	13,000
Assumed % Employed	75%
PMPM Cost to Plan	$115.27
Adult Rate PMPM	**$119.83**
Child Rate PMPM	**$74.29**
Total Annual Cost	$179,827,641
Employer Subsidy	25%
Member Cost (Employed Population only)	25%
Annual Uncovered Cost of Benefits	**$112,392,276**

Caveats

As the previous Tables illustrate, the annual uncovered cost of benefits is highly variable and sensitive to the critical assumptions underlying the estimate. One of the most critical assumptions pertains to the actual size of the uninsured population. While estimates of the size of the uninsured population in San Francisco can be obtained from the Current Population Survey (CPS) – the predominant source for Dr. Bindman's estimates – the small size of the San Francisco County sample results in wide fluctuations in these estimates. For example, the 1996 Survey showed San Francisco with an uninsured population of nearly 118,000 while the 1997 figure was approximately 160,000. Both years showed the self-employed and non-working as 18-20% of the total population. Assuming that San Francisco has a population of 775,000, then the number of uninsured who are self-employed or non-working is roughly 32,000, based on 1997 CPS estimates.

In this report, we have provided cost estimates for the most-likely scenarios based on Dr. Bindman's research. We have modeled these scenarios under two different comprehensive benefit packages and also assuming a more limited benefit package. Additionally, we have estimated the net cost of the program using two sets of assumptions for the portion of the premium to be borne by the employer and employee in the working populations: one, that the employer and employee each pay for 20% of the premium per member (40% total) and two, that the employer and employee each pay for 25% of the premium per member (50% total). The 20-25% employer subsidy assumption is low relative to a standard population while the employee cost-sharing assumption of 20-25% is average.

All of these assumptions produce significant differences in the net cost of the program to the City. In separate Exhibits available through the San Francisco Department of Public Health, we varied assumptions including the adult/child ratio and the unemployment rate to estimate the impact on the overall costs of the program. If the rate of unemployment in the uninsured population is closer to 50%, the net cost to the City will be 18-30% higher than that shown in the preceding Tables. Holding all other variables constant, if the ratio of adults to children is closer to 60%/40%, the net cost to the City will be approximately 12% lower than that shown in the preceding Tables.

Table 1

SF Single Premium Rates (1998)				
Program	**Blue Shield**	**HealthNet**	**Kaiser**	**PacifiCare**
HIPC (Standard)	$116.81	$116.61	$96.89	$116.94
HIPC (Preferred)	$135.80	$130.60	$109.23	$130.23
CalPERS (Basic)	$170.05	$167.53	$156.82	$131.82
HSS	N/A	$158.29	$157.18	$142.00

Table 2

Total PMPM Underlying Rates Above				
Program	**Blue Shield**	**HealthNet**	**Kaiser**	**PacifiCare**
HIPC (Standard)	$110.61	$110.42	$91.75	$110.73
HIPC (Preferred)	$128.59	$123.67	$103.43	$123.32
CalPERS (Basic)	$129.27	$127.36	$119.21	$131.82
HSS	N/A	$126.76	$129.34	$128.22

Table 3

Age/Sex Factors (Relative to HIPC Standard)				
Program	**Blue Shield**	**HealthNet**	**Kaiser**	**PacifiCare**
HIPC (Standard)	1.00	1.00	1.00	1.00
HIPC (Preferred)	1.00	1.00	1.00	1.00
CalPERS (Basic)	1.14	1.14	1.14	1.14
HSS	N/A	1.03	1.09	1.00

Table 4

PMPMs Net of Age/Sex Differences				
Program	**Blue Shield**	**HealthNet**	**Kaiser**	**PacifiCare**
HIPC (Standard)	$110.61	$110.42	$91.75	$110.73
HIPC (Preferred)	$128.59	$123.67	$103.43	$123.32
CalPERS (Basic)	$113.49	$111.81	$104.66	$115.73
HSS	N/A	$122.64	$118.65	$128.82

Table 5

Benefit Plan Relative Values (Relative to HIPC Standard)				
Program	**Blue Shield**	**HealthNet**	**Kaiser**	**PacifiCare**
HIPC (Standard)	1.00	1.00	1.00	1.00
HIPC (Preferred)	1.16	1.12	1.12	1.12
CalPERS (Basic)	1.20	1.16	1.16	1.16
HSS	N/A	1.14	1.16	1.14

Table 6

PMPMs Net of Benefit Plan Differences				
Program	**Blue Shield**	**HealthNet**	**Kaiser**	**PacifiCare**
HIPC (Standard)	$110.61	$110.42	$91.75	$110.73
HIPC (Preferred)	$110.85	$110.42	$92.34	$110.11
CalPERS (Basic)	$94.58	$96.39	$90.22	$99.77
HSS	N/A	$107.58	$102.29	$113.00

City and County of San Francisco
Benefit Plan Summaries

Benefit Summary	HIPC HMO Standard	HIPC HMO Preferred	CalPERS HMO Basic	Health Service System – Kaiser	Health Service System – Health Net
Hospital Inpatient	$100 copay per admission	no charge	no charge	no charge	no charge
Hospital Outpatient	$15 copay per visit	$5 copay per visit	no charge	$5 copay per visit	no charge
Emergency Room Services	$50 copay per visit; waived if admitted	$50 copay per visit; waived if admitted	$35 copay per visit; waived if admitted	$5 copay per visit; waived if admitted	$25 copay per visit; waived if admitted
Skilled Nursing Facility	$100 copay per admission; limit – 60 days per benefit period	no charge; limit – 60 days per benefit period	no charge; limit – 100 days per benefit period	no charge; limit – 100 days per benefit period	no charge; limit – 60 days per benefit period
Hospice	?	?	no charge	no charge, limit – 100 days per benefit period	no charge, limit – 60 days per benefit period
Office Visits	$15 copay per visit	$5 copay per visit	$5 copay per visit	$5 copay per visit	$5 copay per visit
Prenatal Care/Pediatric Visits (age <2)	$5 copay per visit	$5 copay per visit	$5 copay per visit	$5 copay per visit	$5 copay per visit
Preventive Care Visits	$15 copay per visit	$5 copay per visit	$5 copay per visit	$5 copay per visit	$5 copay per visit through age 17; $25 copay per visit – adults
Allergy Testing	$15 copay per visit	$5 copay per visit	$5 copay per visit	$3 copay per visit	$5 copay per visit
Mental Health – Inpatient	$100 copay per admission; limit – 10 days per benefit period	no charge; limit – 10 days per benefit period	no charge; limit – 30 days per benefit period	no charge, limit – 45 days per benefit period	no charge, limit – 30 days per benefit period
Mental Health – Outpatient	$20 copay per visit; limit – 20 visits per benefit period	$20 copay per visit; limit – 20 visits per benefit period	$20 copay per visit; limit – 20 visits per benefit period	$20 copay per visit, limit – 20 visits per benefit period	$25 copay per visit, limit – 20 visits per benefit period
Substance Abuse – Inpatient (detox only)	$100 copay per admission	no charge	no charge	no charge	no charge
Substance Abuse – Outpatient	max payment by health plan of $20 per day, limited to total of $400 per benefit period	max payment by health plan of $20 per day, limited to total of $400 per benefit period	$5 copay per visit, limit – 20 visits per benefit period	no charge for up to 30 days per benefit period of residential treatment	rehab treatment programs covered
Prescription Drugs	• Generic (30-day supply) - $10 copay • Brand (30-day supply) - $15 copay • Generic (90-day supply) - $20 copay • Brand (90-day supply) - $30 copay	• Generic (30-day supply) - $5 copay • Brand (30-day supply) - $10 copay • Generic (90-day supply) - $10 copay • Brand (90-day supply) - $20 copay	$5 copay per script	$5 copay per script	$5 copay per script, $15 copay for non-formulary

Benefit Summary	HIPC HMO Standard	HIPC HMO Preferred	CalPERS HMO Basic	Health Service System – Kaiser	Health Service System – Health Net
Vision Care	limited to preventive care exams for minors	limited to preventive care exams for minors	$10 copay per visit; limited to one visit per year	$5 copay per visit; no charge for lenses and $80 frame allowance every 24 mths	$10 copay per visit; $25 copay for lenses/ frames; exam, lenses and frames furnished every 24 mths
Physical Therapy	$15 copay per visit up to 60-day period per condition	$5 copay per visit up to 60-day period per condition	$5 copay per visit up to 60-day period per condition	$5 copay per visit up to 60-day period per condition	$5 copay per visit up to 60-day period per condition
Chiropractic Care	not covered?	not covered?	$5 copay per visit; limit – 20 visits per benefit period	not covered	not covered
Home Care	$15 copay per visit	$5 copay per visit	no charge	$5 copay per visit	$5 copay per visit
DME	no charge	no charge	no charge	no charge	50% copay
Infertility Testing	copay – 50% of contracted rate	copay – 50% of contracted rate	copay – 50% of charges	?	?
Yearly OOP Maximum	$2,000 per person; $4,000 per family	$2,000 per person; $4,000 per family			

COMMENTS FROM THE
COMMUNITY FORUMS AND PRESENTATIONS
MAYOR'S BLUE RIBBON COMMITTEE ON UNIVERSAL HEALTH CARE
(Forums and Presentations held during January 1998 through March 1998)

Committee Representation

- Consumer representation is insufficient on the Committee.

Cost of Health Care

- The page entitled "Health Care Expenditures -- 1996" should be revised. The amount of money spent to care for persons with catastrophic illnesses should be shown separately more realistically reflect average cost per citizen utilization.

Eligibility Issues

- The residency requirement will be difficult for employers. It is not uncommon for employees to live in neighboring counties. The residency requirement means that employers will be treating some employees differently (i.e., those who have been San Francisco residents for six months will be eligible to obtain the health care coverage and those who are not will not be eligible). This is an equity issue and will affect employee moral.

- There are a number of self-employed workers and temporary workers. The purchasing program must ensure that self-employed workers are eligible for the program.

- The children of college students should be included in the eligible population.

- Are undocumented residents eligible to participate in this purchasing program?

- To assist in determining who is eligible for the program, the Committee should consider doing a needs assessment for the various uninsured populations to guide to development of the scope of services.

- Can a person who enrolls in this program as an unemployed or self-employed persons early in the year but later gains employment with a firm that offers health care coverage disenroll from the program?

- Can an employed person enroll in the program even if their employer decides not to?

- Which individuals will be eligible for participation in this insurance program? Is it only for the indigent?

Employer Issues

- A minimum participation period should be established for employers. This will be necessary to ensure that employers are not allowed to pull out of the program hastily.

- The page entitled "Health Insurance San Francisco Bay Area" suggest that small employers are not doing their fair share by offering health care coverage. The Committee should take into account that for small employers the overriding issue is affordability given the instability in monthly revenues.

- Besides making the cost of providing health care more affordable through some public sector subsidy, what other "local financial incentives" is the Committee looking at to make it attractive for businesses to participate?

- Need to recognize the numerous restrictions that small employers work under (profits, seasonal employment, City requirements, etc.).

Employee Issues

- Need to focus the program on employee issues to make it attractive to sign up given the fact that they will still be able to get health care coverage even if they do not sign up for the program.

Financing the Cost

- If the total premium is $120 pmpm, what portion of that will be paid by public, what portion will be paid by employer and what portion will be paid by the member?

- The administrative cost of the program seems very high. How was this percentage derived? The purchasing program should ensure that it is not doing any duplicative administrative and operational functions that a health plan would do As much money as possible should go to the provider.

- The co-payment seems high, particularly for low-income persons Has the Committee looked at either lowering the co-payment or not having a co-payment? Means testing for enrolled members should be instituted.

- Co-payments have been shown to discourage utilization of preventive care Unemployed persons should not be required to pay either a premium or a co-payment.

- Will Medicaid dollars be used to finance this program?

- What are the public sector funds that will be used to finance this program? Where are these funds currently going in the City and what services to they support?

- Was the cost of providing services to persons with HIV/AIDS factored in?

- Will funds be taken away from the Department of Public Health to fund this purchasing program?

Health Plan Provider Issues

- While choice in health plans will be necessary, the Committee should not design this purchasing program with too much choice. This becomes complicated for employers.

- What criteria will be used in selecting health plans/providers for this purchasing program? They should have experience serving vulnerable populations and populations that may require more support services.

- What health plans will participate?

Implementation

- How will this insurance program get started?

- Who has to authorize the formation of a new public authority and the development of this program?

Interfacing with Other Health and Social Service Programs

- Need to determine how this purchasing program will interface with Healthy Start and other efforts to ensure health services for children. There should be linkages between these types of efforts.

- Need to ensure interface with social services since providing health insurance is not the sole determinant in improving health status. It the environment where a person lives has not changed then health care coverage will not be sufficient. Need to make sure that vulnerable populations also receive case management services.

Labor Issues

- This is a significant change in how the City will provide services to the uninsured. Is labor aware of this proposal and are they supportive of it?

Proposed Phase-in

- Consider using residents in the 94124 zip code in the first phase-in.

- When is the phase-in going to begin?

- How many individuals will participate in the pilot (i.e., number of working uninsured, non-working uninsured, children, etc.)?

Purchasing Pool

- How many enrollees will be necessary in the purchasing program to ensure that it survives financially?

- The HIPC is similar to the Committee's purchasing pool. However, HIPC requires a certain percentage of the employers work force to sign up for the program. Is the City's purchasing program going to have a similar requirement? If so, what will the percentage be?

Risk Adjustment

- In addition to doing risk adjustment within the health plans to take into account adverse selection, the Committee should also think about doing service adjustment for persons with extended service needs.

Safety Net Issues

- This feels similar to what happened with Medi-Cal managed care -- patients that once relied on safety net and traditional providers will be funneled into commercial health plans. Has the Committee looked at the impact on safety net providers?

- Does the Committee understand that by providing choice, providers will be affected? Populations that they have traditionally served may no longer continue with them.

- The written presentation should state clearly that there is a commitment to preserving the safety net.

Scope of Benefits Issues

- Dental service should be included in the scope of benefits. Dental services -- particularly preventative dentistry -- are as necessary as other physical health services.

- Will transgender procedures and subsequent health services related to such procedures be included in the scope of benefits?

- Generally disappointed that there are only limited mental health and substance abuse services in the benefits package. This perpetuates the notion that behavioral health should not be fully incorporated within a benefits package. How can fragmentation be reduced and would the Committee reconsider expanding the mental health and substance services benefits?

- Why is vision for minors only available? Vision impairment due to health conditions should be included within the scope of services.

- Is there a co-payment of pharmacy? If a person has multiple prescriptions, this can get expensive and be cost-prohibitive.

- How will the coverage provided relate to long-term care services being developed by the Long Term Care Pilot Project Task Force?

Uninsured Data

- Need to determine the number of uninsured in the 94124 zip code.

Voluntary vs. Mandatory

- Given the City's leverage over contracting, etc., the City has the option to make this mandatory for all businesses. It should consider this approach.

- The program is based on voluntary enrollment by employers and individuals. However, it is my understanding that if an employee is offered health care coverage, then they must accept it. Therefore, how will individuals be able to decline coverage?

- Why can't the City require businesses to provide health care coverage and make this a mandatory program? This is the way to ensure that all residents have insurance.

- While the Committee is recommending a voluntary approach, what assurances are there that the City will not mandate this program?

Forums Held

- Community Forums (5) -- Locations
  - Southeast Community Facility
  - Ella Hill Hutch Comm. Center
  - Horace Mann Middle School
  - Department of Public Health
  - UCSF Laurel Heights Campus

Presentations Made:

- City College of San Francisco
- Department of Public Health Staff
- Long-Term Care Task Force
- Neighbor to Neighbor
- Residential Care Providers
- San Francisco Chamber of Commerce
- San Francisco General Hospital Management Forum
- San Francisco Health Commission
- San Francisco Small Business Commission
- Small Business Community
- UCSF Dental/Public Health
- West Bay Hospital Council – San Francisco Section